DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2007

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

NONDEPARTMENTAL WITNESSES

[CLERK'S NOTE.—The subcommittee was unable to hold hearings on nondepartmental witnesses. The statements and letters of those submitting written testimony are as follows:]

DEPARTMENT OF LABOR

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF WORKFORCE BOARDS

Chairman Specter, Ranking Member Harkin, and distinguished Members of the subcommittee, my name is Stephanie Powers, Chief Executive Officer of the National Association of Workforce Boards (NAWB). I am submitting this testimony on behalf of Leonard Wilson, Chairman of the Board of Directors of NAWB, and the Nation's workforce investment boards regarding fiscal year 2007 funding for programs authorized under the Workforce Investment Act (WIA). We appreciate this opportunity.

Workforce Investment Boards (WIBs).—The Nation's 589 local, and 52 State workforce boards provide strategic guidance and leadership for the design and implementation of the Nation's workforce investment system, which includes 2,000 comprehensive One-Stop Career Centers. The boards have approximately 13,000 private sector members who volunteer their time to insure that the workforce investment programs are connected with community economic development priorities and employers' needs.

The Workforce Challenge in the United States.—More than at any time in our history, the American workplace demands a competitive and responsive workforce. The complex interplay of technology and globalization, coupled with profound demographic changes, have set in motion a set of difficult challenges to our economic prosperity. Business, political leaders, and policy experts often disagree as to the proper mix of monetary, trade, taxation, and regulatory policy to ensure prosperity in the years ahead. Nonetheless, virtually all the experts, public and private, agree that a key ingredient to our economic success lies in the capacity of the American workforce to offer knowledge, skills and innovation to the economy. Yet, the administration continues to propose potentially devastating reductions in funding, and policy changes for the Nation's workforce investment system that, if adopted, would virtually eliminate our workforce preparation infrastructure, and decimate United States efforts to maintain a skilled workforce.

As your Committee examines the President's fiscal year 2007 budget proposal, and deliberates over workforce investment and employment services funding, the National Association of Workforce Boards respectfully asks that you: (1) Weigh the potentially devastating impact of the administration's budget and policy recommendations for WIA and the Wagner-Peyser Act; (2) Decide instead to enhance and build on strengths of locally-based, private sector-led Workforce Investment system and its successes; and (3) Invest, not disinvest in the Nation's workforce devel-

opment system, funding programs authorized under WIA and the Wagner-Peyser Act at not less than the fiscal year 2005 funding levels.

In 2006, we know that it is crucial for our workers to be ready, willing, and able to respond to the pace of America's changing workplace needs. On the demand side, employers must be ready to invest in the capacity of all workers, not just those already skilled and educated. Collectively, our Nation must commit resources at all levels, to raise the performance of students and workers at the bottom, while improving the performance of those in the middle and top. We must ensure that all low wage and structurally unemployed workers have the opportunity to gain new high-value skills, maintaining important transitional income support and health insurance while upgrading skills and changing careers. Our public policy investments need to embrace the realities of a 21st Century workplace and develop a system that will help our employers and workers compete successfully. Success for the future will depend not just on educating all Americans to much higher standards, but also to different standards.

We believe that the complexity of what we are facing requires our Nation to maintain a strong Federal commitment to coherent and consistent public investment policies that address the needs of workers and employers alike. There will be a price to broad prosperity if we ignore the sum of these growing realities:

—*Broad Lack of Workforce Proficiency in Technology*.—The Global Affairs Director of the Microsoft Corporation, Pamela Passman, in a recent speech at NAWB's annual conference, expressed her company's concerns about the "readiness of the American workforce to embrace technology as an essential tool of the knowledge economy." She stressed that there is no concern with countries embracing technology, innovating, and investing in education and skills training, as long as America is doing the same. But she warned about the lack of proficiency of adults to search, comprehend, and use information (13 percent) and to perform computational tasks, despite the Nation's focus on improving math and science skills (13 percent). These deficiencies, if not quickly addressed, will hamper growth and innovation expansion for "employers who are demanding more skills that revolve around knowledge creation, collaboration and communication, and analysis."

—*A Growing Talent Shortage*.—The well-regarded staffing company manpower asserts, in a recently released white paper entitled Confronting the Talent Crunch: What's Next States, "There already is a talent shortage in many areas of the global labor force, a situation that will grow more widespread across more jobs over the next 10 years—and could threaten the engines of world economic growth and prosperity." The Bureau of Labor Statistics predicts a shortfall of 10 million workers in the United States by 2010, which may exert additional strain on the talent pool availability.

—*Demographic Reality #1: Aging Workforce*.—The first of the baby boomers has turned 60 this year. Older workers will be leaving the workforce much faster than new workers are entering, and as they leave the workforce they will take with them an incredible wealth of education, talent, skills, experience, and traditional work ethic. For example, more than 50 percent of the current science and engineering workforce in the United States is approaching retirement. Given this, should we be concerned that China graduates four times as many engineers as the United States? Or that out of the 1.1 million high school seniors who took a college entrance exam, just under 6 percent indicated plans to pursue a degree in engineering—nearly a 33 percent decrease in interest from the previous decade (Passman, 2/27/06).

—*Demographic Reality #2*.—Immigrants and Untapped Pools of Potential Workers. The future workforce will be far from homogeneous. The predicted growth in the American labor force will come largely from immigrants who are less likely to quickly replace the level of skills that will be departing with the boomers' exodus. If these trends continue, and they are predicted to do so, increasing workforce remedial interventions will be needed to deal with English language deficiencies and to boost basic education proficiencies. Employers will also need to be better prepared to provide various accommodations for both an aging workforce and people with disabilities who are likely to enter the workforce in greater numbers as technology and civil rights protections enable higher rates of their participation. The continued growth of working women will require more flexible working schedules and family leave policies as their child care and elder care responsibilities require them to balance work and family commitments.

So the question looms, how can workers be assisted in navigating and managing their work lives in this complex global economy? Will companies be competitive without access to a higher-skilled workforce? And importantly, how should public

policy respond to the realities of the societal changes and the vagaries of the global economy? The President acknowledged in his State of the Union message the increasing concern about national competitive challenges, but we regret that his budget proposal for workforce investment does not support his agenda in this area; in fact, it misses the mark. It is baffling why the administration would propose such deep cuts in the Nation's workforce investment programs in the face of mounting evidence, and their call for attention to American competitiveness. We should increase, not decrease these investments.

The WIA system currently provides a wide range of vital services to over 16 million U.S. jobseekers and employers through its One-Stop delivery system, including labor market information, job search assistance, guidance and counseling services to help workers find the right jobs, and employers find the right employees. The system provides essential rapid response and transition assistance to dislocated workers; support services for individuals pursuing first time employment; and assistance for low-wage workers in search of career growth opportunities leading to self-sufficiency. It is designed to help jobseekers access the education and training they need to succeed in the new knowledge economy; to meet the skill needs of employers.

According to the U.S. GAO, the WIA system spent over 40 percent of its funding in fiscal year 2003 on training for jobseekers in the United States, and this estimate did not take into account funds used to pay for computer lab workshops in software applications, basic keyboarding, computer skills training, and even certain adult basic education classes offered through the One-Stop delivery system. Nor did it take into account training arranged by the One-stops but not paid for with WIA funds.

As your Committee deliberates on funding for the U.S. workforce investment system, and considers the President's 2007 budget proposal, we respectfully ask that you:

(1) Enhance and Build on Workforce Investment Boards' Successes

The United States' Council on Competitiveness and the experts who participated in its National Innovation Initiative identified innovation as the single most important factor in determining America's success through the 21st Century. They identified the key ingredients for innovation as talent, investment, and infrastructure, and urged the knitting together of these strands to foster new innovation "hot spots" in regions across the United States than can sustain jobs and wage growth. It is crucial to find ways bring businesses, workers, researchers, economic developers, entrepreneurs, educational and training institutions, and governments together, at the regional level, to identify and develop their strengths and capacity for innovation.

In fact, the Workforce Investment Act is predicated on such a collaborative model. Many Workforce Boards across the country are already performing this convening/brokering role that is essential to regional economic prosperity. To eliminate funding for this work as proposed in the administration's fiscal year 2007 budget, would be to put a stop to what hundreds of local workforce investment boards from around the country have already begun—the building of collaborative regional, knowledge-based economies. Let me share some examples with you.

—*The Finger Lakes Workforce Investment Board*.—In New York identified and developed career maps for photonics and biotechnology as potential growth sectors for a region in transition. The WIB with K–12 schools, the business community, community colleges and the Syracuse University School of Education identified the foundational skill standards for these industries and recommended steps for secondary schools to realign curricula in science, math and technology, as well as ways to build awareness of the career opportunities and pathways existing in these sectors.

—*The South Florida Workforce Investment Board*.—That serves the Miami metro area served 7,648 employers and placed 69,634 clients in jobs this past year. They calculate the return on investment to the community of $11.01 for every dollar of workforce funds invested. In an area of historically high unemployment, these results are the fruit of the partnerships that the WIB has fostered with economic development agencies, business and the community's public agencies.

—*The Brevard Workforce Development Board*.has created an extensive menu of business services and targeted those growth industries such as healthcare, manufacturing, and Aerospace that are growing jobs in their community, which is one of the hottest job growth areas in the country. Their ability to continue this work would be diminished, if not eliminated, if the proposed budget cuts and Career Advancement Account proposals are enacted.

—*The Northwest Wisconsin Workforce Investment Board*.—Developed the "Talent Profiling System" (TPS), a soft skills matching tool, to respond to the over-

whelming requests of employers to find people that fit their jobs. Since its implementation, TPS has achieved results ranging from having the highest employer penetration rate in the State's 11 Workforce Development Areas to a decrease of $916.88 to $420.24 in cost-per-placement and realized $4.22 Return On Investment (ROI) for each tax dollar invested.

—*The North Central Texas Workforce Development Board*.—Serves a fourteen county region with 1.6 million people that surrounds the Dallas/Fort Worth area. This board supports small businesses by serving as the HR department for small companies. In this vital role they provide personalized attention for recruiting and placement; applicant screening; and on-site assistance with interviewing. Services to small business such as these, the engine of economic growth, will be severely limited by 15 percent + reductions in funding and the Career Advancement Account proposal.

—*The Greater Peninsula Workforce Development Consortium*.—In Newport News, Virginia created The Manufacturing Pipeline Partnership for their local manufacturers. Participating manufacturers have been able to significantly improve their hiring practices through this collaborative effort. Northrop Grumman Newport News was able to hire 922 workers in skilled trades' positions, Siemens VDO Automotive, hired 100 plus workers for crucial positions in their advanced technology production areas. The WIB and the partnership it convened is directly contributing to the long term economic vitality of the region. This would not have been possible without the WIB's convening role, and WIBs would effectively be eliminated by the administration's budget cuts.

(2) Weigh the Potential Impact of Cuts on the Workforce Investment System and its Customers

The administration's fiscal year 2007 budget proposes a new 15 percent cut in funding for WIA and Wagner-Peyser. These reductions would be applied to a workforce investment system that has already sustained funding reductions over the years, and is stretched very thin. Simply put, our system cannot sustain any further cuts without having to close numerous One-Stop Centers throughout the country, and cut back on services provided to those in need (eg, dislocated workers, the structurally unemployed, low wage workers in search of self-sufficiency, at-risk youth, and employers).

These negative consequences of funding reductions do not even take into account the potential devastation that would be caused by the administration's policy recommendations contained in the fiscal year 2007 budget. In her testimony before your Committee, Secretary of Labor Elaine Chao indicated that the One-Stop delivery system would be preserved under the administration's fiscal year 2007 proposal. She stated this despite the fact that 75 percent of the funding for States under their consolidated proposal, would be required to be spent on Career Advancement Accounts—leaving less funding for all other system functions and services, than now provided for the Wagner-Peyser program alone.

The real impact of the administration's proposal (in total) would be the elimination of most of the local Workforce Investment Boards around the country, and the closure of most of the One-Stop Centers. With only 22 percent of WIA and Wagner-Peyser funding, States would be forced to provide all remaining services other than training. Funds to engage the private sector, both through the boards and through business services would be immediately impacted. The loss of the private sector engagement and focus would be diametrically opposed to the original Congressional intent of WIA and to calls from the country's leaders on U.S. competitiveness. Discussions with our colleagues around the country indicate that the impact on the workforce system infrastructure would be dramatic and would effectively dismantle much of the strategic partnership work, employer outreach, and physical One-Stop infrastructure that the WIBs have spent the last 5 years crafting. Innovative programs developed in partnership with employers and economic development, such as incumbent worker, industry sector, career ladder, and layoff aversion programs would be abruptly halted. And tragically, the private-sector leadership of the workforce boards, that has taken us so long to build, would be dismantled and swept under the rug. We believe this leadership and participation should be cultivated, not marginalized, particularly at a time when business leadership and employer engagement in the system is growing. It would be hard to find many other Federal programs where the business community has such a direct role in determining how Federal tax dollars are used in local communities.

When WIA was enacted in 1998, it was clear that Congress intended a significantly enhanced role for business vested in the Workforce Investment Boards. As WIA has matured these past 5 years, we believe that this strategic oversight has turned out to be a highly desirable value proposition and we urge Congress to con-

tinue a strong endorsement of the approach by maintaining and increasing WIA funding that insures the private sector's engagement in the public workforce system.

(3) Invest, Not Disinvest

We applaud the efforts of the subcommittee to provide funding for WIA at levels as close to constant as possible in these increasingly difficult budgetary times. NAWB knows that there are many pressures on the Federal budget and many legitimate requests for funding. However, we submit the competitive posture of the Nation needs to be placed at the top of the priority list, and urge you to fund WIA and Wagner-Peyser at the fiscal year 2005 levels.

While the Department of Labor may claim there is excess unspent money in the WIA system to justify their recommended budget cuts, they, in fact, are not presenting the facts accurately. The GAO's 2002 study clearly disputed this claim. And since the original claims of slow expenditures and excessive carryover were made, the WIA system has significantly diminished system carryover to less than 30 percent of its accrued expenditures—the standard proposed by the administration for WIA reauthorization, and included in both the House and Senate WIA reauthorization bills.

In summary, when WIA was enacted, it was intended to ensure that all Americans have access to the information, job search assistance, and training they need to qualify for good jobs, and to successfully manage their careers in the new economy of the 21st Century—we urge you not to turn your backs on America's workforce investments. . . . they are about our future prosperity, and ultimately our national security in the purest sense.

Thank you for your support in the past, and for this opportunity to submit testimony.

PREPARED STATEMENT OF THE NATIONAL JOB CORPS ASSOCIATION

JOB CORPS WORTHY INVESTMENT TO AMERICA'S YOUTH

Six Million Youth Eligible to Participate

On behalf of the National Job Corps Association (NJCA), we want to thank the Labor, Health and Human Services and Education Appropriations Subcommittee for its unwavering dedication to Job Corps and the vulnerable disadvantaged young Americans it serves. We appreciate the Committee's strong support of Job Corps in fiscal year 2006. Not only did the Committee provide a funding increase, but it established Job Corps as an office reporting directly to the U.S. Secretary of Labor. With strong bipartisan support, Congress acknowledged Job Corps' 40-year track record of success by eliminating layers of bureaucracy and ensuring department-wide attention on America's most disadvantaged youth.

Job Corps is a voluntary program that serves more than 60,000 young Americans each year, which is only about 1 percent of the nearly 6 million disadvantaged youth that are eligible for Job Corps' services. Over the last four decades, Job Corps has built its reputation as the Nation's largest and most successful residential educational and vocational training program for economically disadvantaged youth, ages 16 through 24. With millions of youth eligible and in need of Job Corps services, it is only with your help that Job Corps can remain a beacon of hope for many young Americans and an excellent example of our government's role in ensuring every American has a chance to succeed in the 21 century economy. Tony Pusateri, a Senior Vice President of Equity Residential in Plano, Texas and member of the National Apartment Association Education Institute observed: "I've been around Washington and seen a lot of government programs that I didn't support, but Job Corps is one program . that I am proud my tax dollars go to."

Unfortunately, the administration's fiscal year 2007 budget request cuts Job Corps by $72 million from the fiscal year 2006 enacted level. We are deeply concerned that such a funding cut would force a drastic reduction in the number of youth Job Corps will be able to serve. While we encourage spending restraint by the U.S. Government, we also believe it is imperative to provide adequate funding to support the young Americans who are our Nation's future.

JOB CORPS OPERATIONS FUNDING

Administration's Fiscal Year 2007 Budget Proposal

The administration's proposal recommends funding Job Corps' operations account at $1.401 billion, a decrease of $64 million compared to the fiscal year 2006 appropriated levels. This level of funding amounts to a 7.8 percent decrease in Job Corps' real-dollar funding from fiscal year 2006.

If the operations account were to be cut by $64 million, more than 3,000 economically disadvantaged young Americans would be turned away from Job Corps. These vulnerable youth, though they have the desire, would not be able to enter Job Corps to complete their high school education and place themselves on a career path. As one of the few national job training programs that has shown consistent positive results, Job Corps has the ability to preserve economic prosperity by equipping thousands of high school dropouts, foster care youth, and other vulnerable youth with job skills to enter gainful employment and become responsible, productive citizens. This cut would limit the opportunities of vulnerable youth who are seeking a way to put themselves back on track for success.

NJCA Fiscal Year 2007 Request

The NJCA requests a total of $1.53 billion for Job Corps' fiscal year 2007 operations account to support at least 44,000 training slots and keep all Job Corps centers at full capacity. This amount is based on the Office of Management and Budget's (OMB) projected 3.3 percent rate of inflation between fiscal year 2006 and fiscal year 2007 as well as additional appropriations to support efforts to improve educational programs on Job Corps centers. The increase would (1) allow the 122 Job Corps centers across the country to operate at full capacity to ensure the programs serves as many eligible youth as possible; and (2) support the U.S. Department of Labor's efforts to ensure the program has the necessary resources to hire capable teachers and ensure the quality of its educational courses.

JOB CORPS CONSTRUCTION, REHABILITATION AND ACQUISITION (CRA) FUNDS

Administration's Fiscal Year 2007 Budget Proposal

The administration's budget proposal recommends funding Job Corps' CRA account at $100 million, an $8 million reduction from fiscal year 2006.

As you know, Job Corps gives young people the opportunity to focus and learn in a safe, stable, and supportive environment. However, the average building on a Job Corps center is 47 years-old—20 years older than the construction industry's recommended lifespan. While the program is committed to addressing the backlog of repairs by developing a 10-year capital improvement plan to construct and repair facilities based on priority, it needs more funding resources.

NJCA Fiscal Year 2007 Request

With respect to Job Corps' capital account, the NJCA requests $130 million in fiscal year 2007. These funds will be used to: repair dorms, classrooms, and other student facilities on existing Job Corps centers; replace deteriorated structures, especially those that threaten the safety and health or violate minimum building codes, including mechanical systems; continue to address the $700+ million backlog of construction and/or repair needs; and provide third year funding for incremental Job Corps expansion.

CONCLUSION

As Job Corps looks to the future to train the next generation of youth, we hope you agree that it remains a Federal program worthy of America's attention and support. Seventy-four percent of Job Corps enrollees are high school dropouts. The typical Job Corps student reads slightly less than the 8th grade level. Most youth who attend Job Corps have never held a full-time job. Thirty-two percent come from families on public assistance. However, through targeted self paced learning and dedicated counselors and teachers, these youth graduate from Job Corps with well-documented improvements in their education and skill levels and more than 90 percent transition into employment, higher education or the military. Job Corps provides thousands of youth a second chance to achieve the American dream.

The NJCA looks forward to working with the members of this Committee to ensure that thousands of disadvantaged young Americans will continue having the opportunity to lift themselves up through Job Corps. We have been encouraged by the Committee's support that have expanded and strengthened Job Corps over the years and hope that we will enjoy that support and confidence in fiscal year 2007 and into the future.

PREPARED STATEMENT OF THE NATIONAL YOUTH EMPLOYMENT COALITION

The National Youth Employment Coalition (NYEC) is a network of over 270 youth employment, education, and workforce development organizations dedicated to promoting policies and initiatives that help young people succeed in becoming lifelong learners, productive workers and self-sufficient citizens. NYEC works to improve the

effectiveness of youth-serving organizations by informing and tracking policy; setting and promoting quality standards; promoting professional development; and building organizational capacity. We thank you for your previous support of programs that provide meaningful job training and youth development opportunities for young people and for the opportunity to submit this testimony.

Youth development/employment programs must be adequately funded because our youth are facing a crisis that has profound implications for their lives, their futures, and our society at large. There are 2.4 million low-income 16 to 24 year olds who left school without a diploma or received a diploma but are unemployed.

Youth development/unemployment programs must be funded at a level commensurate with the need to develop a globally competitive and highly skilled workforce for the jobs of tomorrow and today. Youth face a crisis that has profound implications for the lives, their futures, and society at large. According to a report by Public/Private Ventures, "nationwide, 15 million people between the ages of 16 and 24 are not prepared for high-wage employment. Inadequate education or training is a major reason." A report by the National Association of Manufacturers identified three simultaneous phenomena that together are transforming the American economy and its labor force: global pressures, relentless advances in technology, and demographic shifts that will result in "a projected need for 10 million new skilled workers by 2020."

In the face of persistent youth unemployment and changes in the labor market which require more knowledge and skills, the administration's proposed 2007 budget for WIA and Employment Services programs, is a matter of serious concern. It calls for a 15 percent reduction in these important programs and perpetuates the downward trend that would leave employment and training programs $1 billion below funding levels of 5 years ago.

Unless Congress rejects these proposals, many thousands of youth will continue to lack the opportunities and supports necessary to succeed in the 21st century workplace. NYEC urges you to increase investment in programs under the Workforce Investment Act (WIA) and to restore funds for Perkins Act programs, TRIO, and Gear-Up, and the Reintegration for Young Offenders Program.

These programs are needed because unemployment among youth is unacceptably high. While adult unemployment averaged 5 percent in the last quarter of 2005, the unemployment rate among youth 16–19 was 16.1 percent; more than three times as high. A recent study from Northeastern University's Center for Labor Market Studies found that between 2000 and 2004, the number of employed teens declined by nearly 1.3 million.

Since fiscal year 2002, our Nation has been in the process of disinvesting in youth employment and development programs. If this current round of cuts is implemented, investment in the WIA youth programs will have dropped by more than 38 percent from $1.4 billion in fiscal year 2002 to $841 million in fiscal year 2007. This when according to the National Center on Education and the Economy we need "to invest in training on a scale that supports the well-being of the Nation's economy and so that it is not just a privilege for the lucky few."

The administration's disinvestment runs counter to its own philosophy of investing in programs that work and divesting from programs that do not work. These programs work. According to the U.S. Department of Labor's fiscal year 2005 Performance and Accountability Report, in Program Year 2004 (July 2004-June 2005), WIA programs exceeded the Department's target for Diploma Attainment among youth 14–18 (65 percent v. 53 percent), entry to employment for youth 19–21 (72 percent v. 68 percent), and employment retention for youth 19–21 (82 percent v. 79 percent).

The only measure in which programs failed to meet or surpass the Department's target was in cost per participant. According to the Report (page 65), "Average cost per participant was slightly higher than expected—$2,822 vs. a target of $2,663. However, consistent with ETA's vision for youth services, the program has served a higher proportion of out-of-school youth. Out-of-school youth are a more expensive population to serve, with a cost of $3,724 per participant, therefore the overall cost per participant increased over prior years. At the time the cost per participant target was estimated, DOL did not anticipate the full extent of increased expenditures on out-of-school youth." The Report also notes that "Results for PY 2004 continue an upward trend that began with WIA implementation in 1998. All three outcome indicators have increased from PY 2003 and exceeded performance targets. Most important is the continued increase in high school diploma attainment, given the strong statistical correlation between educational attainment and success in the labor market."

It should be noted that even at $2,822 per participant, the cost is below the $3,000 assumed in the administration's proposed Career Advancement Accounts (CAA).

Further, a recent study of comprehensive youth workforce development programs in 36 communities carried out by the Center for Law and Social Policy confirms that Federal investment makes a difference. It found that that between 2000 and 2005 these programs successfully connected out-of-work youth to approximately 18, 456 long term unsubsidized work opportunities; 23,652 internship opportunities; 28,302 short-term unsubsidized jobs; and 23,478 training opportunities. The program reached 42 percent of the eligible target population and 62 percent of the eligible out-of-school population.

According to a 2004 report prepared by Northeastern University's Center for Labor Market Studies, there are 5.4 million 16 to 24-year-olds who left school without a diploma or received a diploma but are unemployed. About 44 percent of them are low-income. With more than 540,000 students dropping out of high school each year the implications of this phenomenon are staggering:

—The earnings gap widens with years of schooling and formal training. In 2003, earnings of male dropouts fell to $21,447; high school graduates earned an average of $32,266; and college graduates earned about $63,000 or triple that of dropouts. As a result, dropouts pay less taxes, are more likely to rely on public assistance, and to be part of the criminal justice system.

—One expert estimates that the United States would save $41.8 billion in health care costs if 2004's 600,000 dropouts were to advance an additional year in educational attainment.

—Approximately 16 percent of all young men, ages 18–24, without a high school degree or GED are either incarcerated or on parole at any one point in time.

—Three quarters of State prison inmates are high school dropouts, as are 59 percent of inmates in the Federal system.

—Increasing the high school completion rate by 1 percent for all men aged 20–60 would save the United States $1.4 billion a year in reduced costs from crime.

—The situation is even more dire in minority communities where as few as 20 percent of black teens are employed at any time, unemployment among young black men aged 16–24 not enrolled in school is about 50 percent, and approximately one-third of all young black men are involved with the criminal justice system at any given time.

According to a paper by written by Professor Michael Wald and Tia Martinez for the Hewlett Foundation, "over the past 25 years the situation for youth who fall off the ladder as they move to adulthood has gotten considerably worse." Nevertheless, inflation-adjusted spending for programs that target at-risk youth dropped by 63 percent from 1985 to 2003.

Youth workforce development programs provide a wide range of services to improve educational achievement, prevent youth from dropping out of high school, and reengage youth who are out of school and out of work. NYEC believes that we must reverse the trend of disinvesting in youth employment and development and fund the WIA youth formula at $1 billion. While we support new programs that help youth prepare for jobs and careers and prevent them from leaving school, funding for untested initiatives like the CAA's should not come at the expense of successful programs that are already stretched to the breaking point.

The administration's fiscal year 2007 budget also proposes to eliminate the Reintegration of Young Offenders Program. According to the Bureau of Justice Statistics, approximately 120,000 youth under the age of 18 are currently incarcerated in juvenile detention centers, State prisons, and local jails. Most will be released in the next few years.

A 1998 study by Vanderbilt Professor Mark Cohen, estimated that each teen prevented from adopting a life of crime could save the Nation between $1.7 and $2.3 million. A report prepared in 2002 for the California State Senate Joint Committee on Prison and Construction Operations stated, "Given the staggering cost of failure, it is hard to imagine any justifiable argument against providing education and services to this population."

Finally, the cost per participant pales in comparison with the cost of alternatives like incarceration. According to the Justice Policy Institute, for example, "incarceration, particularly for juveniles, is an expensive proposition. Each year, capital costs to build new facilities run in the range of $100,000 per cell and operating costs typically exceed $60,000 per cell." The return on investment in the Young Offenders program will be returned many times over.

While NYEC recognizes the administration's continuing commitment to helping prisoners successfully return to society, we are concerned that unless funds are specifically targeted to serving youth, the needs of adults will most often take prece-

dence. At a minimum, funds currently targeted at court-involved youth under the Reintegration for Young Offenders Program should be restored to fiscal year 2003 levels ($54 million).

We support the goals of the President's "American Competitiveness Initiative" and his charge that "We must continue to lead the world in human talent and creativity. Our greatest advantage . . . has always been our educated, hardworking, ambitious people—and we're going to keep that edge." Realizing that goal, however, requires investment in all our citizens.

NYEC has many concerns about the CAA's. We are particularly concerned that the limit of $3,000 a year for up to 2 years will function as a cap that will prevent workers from receiving the best and most appropriate training. A June 2005 GAO Report on the Workforce Investment Act (GAO–05–650) revealed that only 8 percent Workforce Investment Boards cap their Individual Training Accounts at $3,000. Fully 63 percent impose caps of $5,000 or more and 35 percent have caps of $7,000 and up. Fifteen percent have no caps. While this could achieve DOL's goal of increasing the number of people trained, it would call the quality of much of that training into question.

Without Federal investment in effective programs such as those supported by WIA youth formula funds, the Responsible Reintegration of Young Offenders program, and the education programs that provide meaningful pathways from high school to higher education, millions of young people will not make the successful transition into productive employment.

We thank the Committee for its commitment to these important programs that prepare our youth to compete in the global marketplace of the 21st century. We look forward to working with you to strengthen our Nation's youth employment and youth development systems.

PREPARED STATEMENT OF THE OREGON HUMAN DEVELOPMENT CORPORATION

Honorable Chairman, Senator Arlen Specter, and Honorable Committee Members: I want to thank you for the opportunity to share information about the Workforce Investment Act, Section 167 (WIA 167) National Farmworker Jobs Program.

My name is Ronald Hauge and I am the Executive Director of Oregon Human Development Corporation (OHDC), a not-for-profit organization that has provided education, training, and workforce development services for Oregon's migrant and seasonal farmworkers for more than 27 years. Throughout this period Congress has supported focused workforce development services for migrant and seasonal farmworkers within the CETA, JTPA, and WIA Federal workforce initiatives. The underlying reason for this support has been the recognition that migrant and seasonal farmworkers have different characteristics and needs than conventional job seekers who use the Nation's workforce system, and that based on these differences specialized workforce services are necessary to effectively serve this population.

The Department of Labor's own performance reports that show the WIA 167 National Farmworker Jobs Program consistently among the higher performing workforce programs, yet the administration has tried to eliminate the WIA 167 for the last several years. It is only by congressional action that the WIA 167 program continues to exist. Each year this Committee has demonstrated its wisdom and priorities by supporting appropriations to preserve these effective workforce services. Accordingly, I want to thank the Honorable Chairman and Committee Members for your instrumental role in saving the program and maintaining these valuable investments for our Nation's agricultural workforce.

At this time I would like to point out a few features of the WIA 167 program that illustrate its importance.

PROGRAM PERFORMANCE

According the Department of Labor's performance reports the WIA 167 program has achieved entered employment rates above 80 percent, job retention rates of 75 percent, and earnings gains above $4,000. This is unquestionably strong performance given that migrant and seasonal farmworkers are among the most difficult to serve job seekers in the workforce system, and that the program operates largely in rural areas with limited labor markets.

INTEGRATION OF THE WIA 167 PROGRAM INTO THE ONE STOP WORKFORCE SYSTEM

The WIA 167 programs in each State are integrated into the One Stop workforce system on a location-by-location basis. In Oregon, for example, OHDC has six service delivery offices and each of the offices is integrated into the local One Stop sys-

tem by virtue of co-location or other planned systemic integration. OHDC WIA 167 staff are members of local Workforce Investment Boards in each service area.

In Oregon, this integration is acknowledged at the State level and is well documented in the State of Oregon's Two-Year Plan for Title I of the Workforce Investment Act and the Wagner-Peyser Act. The plan states that "strategies in Oregon to promote equal and effective access and service delivery and to promote enhancement and integration of services to MSFWs (migrant and seasonal farm workers) include Oregon Human Development WIA 167 staff have workspace in WorkSource Oregon centers and access rights to the MSFW customer base in each workforce area they serve. With this, they are able to identify from a broader base of MSFW customers those particularly interested in the intensive and training services they can offer and where other staff are able to understand more thoroughly the value added services offered by the WIA 167 for enhanced referral of their customers; *they are seen as a critical component to delivering workforce services to MSFWs.*" (emphasis added)

FEW ALTERNATIVE OPTIONS FOR FARMWORKERS

The mainstream One Stop workforce system is geared primarily toward meeting the "demand" needs of high growth/high demand industries—as part of larger economic development strategies. This leaves lower skilled, hard working farmworkers with few or no options to improve their skills and secure stable employment in the primary labor market. Accordingly, the WIA 167 program becomes the only viable workforce development option for most farmworkers, a place with culturally sensitive, bilingual staff who are experienced in serving farmworkers and who understand the needs of local employers. It is clear that without the WIA 167 program few farmworkers would receive any developmental benefit from the Nation's workforce system.

RURAL COMMUNITY ASSET

The WIA 167 program is a real asset to rural communities. The program adds tangible service capacity and diversity to smaller rural One Stop workforce systems. The program can provide agricultural upgrade training to help agricultural employers enhance worker productivity and stability, thus extending the workforce development system's benefit into the agricultural industry. Also, the program can serve as a foundation to attract other services for farmworkers such as housing, literacy and language training, disaster services, and a variety of emergency services that help stabilize the agricultural labor force in local communities.

As you can see, the WIA 167 National Farmworker Jobs Program is an effective, valuable, coordinated resource that not only benefits farmworkers, but also strengthens the Nation's One Stop workforce system and rural communities.

Before closing I would like to share, in the words of OHDC workforce coordinators, the experience of two farmworkers who were assisted in Oregon Human Development Corporation's WIA 167 program.

Jesus Ortiz [1]

Worked with Glen Walters Nursery for a number of years but had been unable to advance because he did not have any formal education on how to supervise a crew. Most of his knowledge came from first hand experience in the general operation of his department and observing other supervisors. In November 2004 OHDC enrolled Jesus in the WIA 167 National Farmworker Jobs Program. OHDC met with the employer and arranged to provide supervisory skills upgrade training to develop the supervisory skills of Jesus, with the understanding that Jesus would be promoted into a supervisory position following the training. Because Jesus had limited English language skills, OHDC provided the training in Spanish. Jesus completed the training, which was defined as "a success" by the employer, who promoted Jesus into a supervisory position. Jesus also received a wage increase that took his earnings from $7.45 per hour to $11.00 per hour. Now, Jesus not only has the knowledge foundation that makes him a more effective leader and supervisor, but he also has a better income that will dramatically improve his family's well being. It is important to note that this success story would not have been possible if OHDC's WIA 167 program had not been available to provide the training in Spanish—something not available from any other partner in the local One Stop workforce system.

[1] EDITORS NOTE.—Not real names.

Antonio Sanchez [1]

Enrolled in the WIA 167 program in October 2005 at OHDC's Woodburn office. Antonio is a married father of three children. Antonio had worked primarily in agricultural work since he was 18 years old. He was employed with a dairy since 2003, living in employer owned housing. At the dairy Antonio worked long hours and weekends (65–75 hours per week) earning a salary of $2,000 per month with no health or vacation benefits. Antonio was eager to start attending training classes available through the WIA 167 program—his primary goal was to obtain a Commercial Drivers License (CDL) and to secure a commercial driving job. Antonio completed job readiness, customer service, computer, CPR, and CDL trainings within a 6 month period, even though English was not his primary language. He was an active participant with a strong desire to learn as much as he could so he could secure employment that would offer him and his family health insurance benefits, a regular work schedule, and a good living wage so his family could purchase their own home. Upon obtaining his CDL, OHDC referred Antonio to a job interview with Sysco Food Service. According to the Sysco supervisor, Antonio made a great impression during his interview and was offered an entry level position starting at $12.13 an hour—and he will be given the opportunity to transition to a Truck Driver position earning more than $16.00 per hour. The position provides vacation and excellent health benefits, retirement and life insurance. The family is now in the process of purchasing a home of their own.

These two examples illustrate how the WIA 167 program works for both farmworkers and employers.

In closing, I want to thank you again for your ongoing concern for the Nation's agricultural workforce. Although there are many priorities the Committee must evaluate, this is not the time for the Nation to turn its back on our hard working farmworkers who produce and harvest much of the Nation's food and other agricultural products—and who contribute so much for our collective benefit. Therefore, I strongly urge the Committee to maintain or increase the appropriation for the WIA 167 National Farmworker Jobs Program in the 2007 budget.

PREPARED STATEMENT OF THE ASSOCIATION OF FARMWORKER OPPORTUNITY PROGRAMS

Good morning Chairman Specter and members of the subcommittee. My name is David Strauss and I represent the 48 nonprofit and public agencies that provide job training and related services to our Nation's migrant and seasonal farmworkers. They perform these tasks with grants from the United States Department of Labor pursuant to Section 167 of the Workforce Investment Act. As you know, the administration has tried to eliminate this program for the last 5 years. You and the members of your subcommittee have led the way in maintaining it each year, and we thank you for your leadership.

About 2.5 million people labor in the fields and farms of America, from Hawaii to Florida and Puerto Rico, from Maine to California. Estimates are that 85 percent of the fruits and vegetables we eat are hand harvested by farmworkers. The pay is extremely low: most farmworkers earn less than $12,000 per year. Few farmworkers receive the job-related benefits, such as health insurance and sick pay, which we all take for granted. In most States, agricultural workers are not even eligible for unemployment compensation. They live a tough life. Many workers travel hundreds, sometimes thousands of miles in search of work. They get paid only when they perform the work: if the weather is bad or the crop is not as plentiful as the farmer had hoped, they simply do not receive wages. They typically cannot afford decent housing. Their children have to struggle mightily to even complete their public school education. The dropout rate for farmworker youth, especially those who migrate with their parents, is enormous.

For over 33 years the Federal Government has made and kept a commitment to these hardworking people. Special Federal programs were created to recognize the reality that farmworkers often cross State lines to work and live. Thus, we have migrant head start, migrant health, migrant education, and the job training effort called the National Farmworker Jobs Program. These all are federally funded and have guidelines that acknowledge that Governors should not be placed in a position of deciding whether or not agricultural workers qualify for these services under State residency or other localized requirements.

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[1] EDITORS NOTE.—Not real names.

Today, I want to explain the way some of our program operators and staff members helped farmworkers and other rural poor people during the aftermath of the hurricanes of 2005.

When the winds and rains of Hurricanes Katrina and Rita ravaged the gulf States many impoverished groups suffered. Among the hardest hit were the area's migrant and seasonal farmworkers. Thousands lost their jobs and many saw their homes damaged or destroyed. With incomes typically far below the poverty line, most farmworkers have no safety cushion when disaster strikes. To make matters worse, language barriers and cultural isolation often prevent them from accessing emergency services delivered by mainstream providers.

It is hard to picture the severe hardships created by the hurricanes. Potable water could not be obtained, food and fuel were unavailable, and electricity and telephone services interrupted. These deprivations continued for weeks. For many, the migrant and seasonal farmworker job-training agencies provided the only relief.

It must be noted that the four agencies mentioned below can only use Federal migrant and seasonal farmworker job training and assistance funds for eligible farmworkers and their dependents. The head of household must demonstrate eligibility, which includes proof of work authorization or citizenship and evidence of a recent history of performing farmwork. For those ineligible for Federal services, the agencies found other resources. The § 167 WIA agencies in the four States are funded solely through the DOL job training grants for farmworkers. Without Congress's 2005 appropriation for migrant and seasonal farmworker job training, those agencies' doors would have been closed and none of the assistance described below would have happened.

Here is a summary of the § 167 agencies' relief activities:

LOUISIANA

Motivation, Education and Training, Inc. of Louisiana (MET) is the 167 agency in that State. MET was on the ground in the Hammond, LA area a few days after the storm hit. That area had no electric power, or telephone service, gasoline, or clean water. MET set up an intake center in a trailer, powered by a generator. Staff provided emergency services to people who could not be reached by FEMA. Red Cross trucks brought water and ice. MET provided vouchers for food, clothing, rent and other items to over 300 families (made up of over 1,200 people) who otherwise might have starved or been rendered homeless. While much of the community infrastructure, was poorly supplied, the local Wal-Mart was well prepared for the needs of people affected by the storm, and MET worked out arrangements for the vouchers to be used there. The average voucher was about $370 per family. They continue to serve eligible families months after the storm. These vouchers are funded through the § 167 program.

Ineligible families are referred to the Quad Area Community Action Agency, which issues commodities and other goods.

MISSISSIPPI

The Mississippi Delta Council for Farmworker Opportunities (MDC) was one of the few statewide nonprofit organizations to have a nearly intact network following the hurricane. Headquartered in Clarksdale, MDC gave out vouchers and other help to hundreds of seasonal as well as migrant farmworkers. Vouchers were issued to 330 eligible farmworkers and families, and commodities and other supplies were given to 331 other people. Vouchers were provided through § 167 WIA program funds.

The commodity donations were made possible through the efforts of the § 167 WIA agency in Tucson, Arizona: Portable Practical Educational Programs (PPEP). PPEP gathered its own resources, those from the League of United Latin American Citizens, and from World Care. PPEP led two caravans consisting of a total of 14 trucks loaded with relief supplies making the 1,200-mile journey from Tucson to Clarksdale. MDC located a warehouse in Clarksdale, and the supplies continue to be distributed from there to farmworkers and other rural poor families throughout affected counties and in places where evacuees from the Gulf Coast and the New Orleans area are sited. MDC is also shipping supplies to their colleagues at Telamon Alabama for use in the Mobile area. As in Louisiana, the people they are serving are mostly outside any area of help provided by FEMA or the Red Cross.

MDC is currently assessing farmworker needs in the counties of Scott, Simpson, Smith, Forrest, Greene, and George. There appears to be a tremendous need for housing for farmworkers whose homes were devastated by the storms.

ALABAMA

Telamon Alabama is the § 167 WIA agency in that State. It has provided direct voucher services to at least 25 farmworker families dislocated by the storm, primarily in Baldwin County. They have assisted about 200 others. Very little presence of FEMA or the Red Cross is reported for the farmworker areas of that county. A particular problem is that the fishing industry on the coast was devastated. Shrimp harvesting businesses operated by Vietnamese immigrants and others were virtually wiped out by the storm. Telamon is limited by the amount of help it can provide in two ways: its § 167 WIA grant is about half that of Mississippi and considerably less than Louisiana's. In addition, there are large numbers of undocumented farmworkers, and there are few resources for referral for them. Telamon is providing as many persons as they can with commodities that have been shipped in from Arizona.

FLORIDA

The counties in which farmworkers were most affected were not declared disaster areas. That restricted FEMA's involvement. The Florida Department of Education's Adult Migrant Programs (FDOE) operates the farmworker job-training program in Florida. FDOE funds a number of sites with § 167 WIA subgrants. Those sites have assisted over 400 farmworkers and their families, primarily obtaining resources from the United Way agencies that use Community Services Block Grant funds. A number of private funds were set up in the aftermath of the 2004 hurricanes, and these funds were used to alleviate suffering from these storms. The 400 farmworkers they have already assisted were working in nurseries that were wiped out by the storm. However, the avocado orchards that were to be harvested were severely damaged, and the planting season that farmworkers rely upon in late fall were delayed because of the wet conditions.

SUMMARY

In Alabama, Louisiana, and Mississippi, the agencies that operate the programs funded under § 167 of the WIA served as primary relief sources for migrant and seasonal farmworkers and their families in the wake of Hurricanes Katrina and Rita. At least 1,800 farmworkers and family members have received emergency services to date, either in the form of vouchers or relief supplies. Hundreds of other people in those States and in Florida were referred to agencies funded to help storm victims. There are medium- and long-term problems that farmworkers will experience that are not yet fully known. Much farm labor housing in Mississippi and Alabama has been destroyed, and future prospects for employment in agriculture are unclear.

It is crucial that these four organizations were in place when the rural poor of the affected areas needed them. Had the funding for these organizations ceased in 2005 as the Department of Labor recommended, thousands of hard-working, low-paid farmworkers and their families would face life-threatening deprivations. And the growers and farmers that rely on them would be facing a much more uncertain future as they try to rebuild their agricultural enterprises. Fortunately, despite DOL's attempts to eliminate this program since 2002, Members of Congress have had the foresight to sustain the migrant and seasonal job-training program.

Without these grants, who would be there to serve the working poor in rural Louisiana, Mississippi, Alabama, and Florida during this terrible time?

PREPARED STATEMENT OF THE CENTRAL VALLEY OPPORTUNITY CENTER

Chairman Specter, and other members of the subcommittee, my name is Ernie Flores and I am the executive director of Central Valley Opportunity Center (CVOC). CVOC is the DOL WIA Title I Section 167 grantee, and also a Community Action Agency, in Madera, Merced and Stanislaus counties in the central San Joaquin Valley of California. At this time I submit my testimony for your consideration and in support of continued funding for the WIA 167 program, operated as the National Farmworker Jobs Program (NFJP) in the DOL. As you are aware, for the past 5 years, the President's budget, and the DOL, have proposed to eliminate the funding for NFJP. If this were to happen, it would effectively end vital employment and training services, job stabilization services, and various educational services that migrant and seasonal farm workers require to either continue working in agriculture, or to transition into year round employment outside of agriculture. It should also be mentioned that the funding for the entire NFJP program is approximately $80 million. Unfortunately, this amount of funding only allows us to serve 3–5 percent of the eligible farmworkers in need of our services.

Although the U.S. DOL has testified that farm workers could be served through the local One-Stop Centers, all partners in the One Stop system, including the One Stop operators and the 167 grantee One Stop partners, are in agreement that the One Stop system is not prepared to served farmworkers. The majority of farm workers have limited English proficiency, possess very little formal education and generally have very few marketable job skills. The only jobs program that is prepared to help farm workers overcome those types of barriers, and become or continue to be gainfully employed, is the WIA 167 NFJP.

The U.S. DOL has also testified before Congress that the NFJP is ineffective and duplicates the work of other job training programs. As to effectiveness, the DOL's own internal performance reports document that the NFJP has attained the highest performance ratings, for all WIA employment programs in the areas of entered employment, wage gains, and retention in employment, during the past 4 quarters. As for duplication, the NFJP generally serves over 95 percent of all migrant and seasonal Farmworkers that are enrolled in any WIA programs during any 12 month program period. Any Farmworkers that are enrolled in other WIA programs are most likely co-enrolled into a NFJP WIA 167 program also.

For the past 27 years CVOC has provided various employment, training and social service programs to migrant and seasonal farm workers and other low income persons in our three county service area in Central California. As is the case with all NFJP grantees, our field offices are easily accessible to Farmworkers since they are located in their communities. CVOC offers the following services under the NFJP grant:

EMPLOYMENT AND TRAINING

—Outreach, assessment and enrollment
—Case management/vocational guidance
—Vocational training
  —Welding
  —Auto Mechanics
  —Cooking/Food preparation
  —General/Advance Business Occupations
  —Cashiering/Merchandising
  —Commercial Drivers License
—English As a Second Language classes
—General Equivalency Diploma classes
—Supportive Services (child care, gas, food, housing)
—Job Readiness Training
—On the Job Training
—Direct Job Placement
—Indirect Job Placement
—Active follow-up services
—Retraining services

In addition to these services, CVOC has leveraged resources with the help of the NFJP grant in order to provide farm workers with services such as energy payment assistance, emergency housing, food vouchers, medical & dental services and various other social services.

In should be understood that there are no other programs in the WIA system that are prepared to meet the employment and training needs of migrant and seasonal farmworkers except for programs like CVOC, and the other grantees of the WIA NFJP. If these programs cease to operate as a nationally administered program, and funding is seriously cut or eliminated, there will literally be no employment and training services for migrant and seasonal farm workers.

I sincerely implore you to continue the funding for the WIA 167 NFJP so that together we can continue to do for the least of our brothers. So that farmworkers can also reap the harvest of the American dream.

At this time I would like to share some of our "success stories." The stories clearly show how the lives of farmworkers, or their dependents, are forever changed for the better when they receive services from the National Farmworkers Jobs Programs grantees.

Thank You.

Isaura Gonzalez

Before coming to CVOC, Isaura Gonzalez was a seasonal cannery worker at Michael Angelo Gourmet, where she was making $9.50/hr. This wage was not too bad considering she dropped out of school in the seventh grade. However, this was a temporary job and offered no benefits. Isaura came to CVOC with a dream. She wanted to obtain her General Education Diploma (GED) and find a year-round job

with fringe benefits. Six months later, all her dreams became true! Isaura successfully completed the CVOC 22-week General Business Occupations course a month early and obtained her GED with an amazing score of 2,910. This score is the highest ever in CVOC's history! She is now working for Hilmar Cheese Company as a Data Entry/Machine Operator Manager making $14.95/hr. She has fringe benefits and a year-round job. Recently, during her first quarter follow-up she said she was expecting a raise soon.

Juan Hernandez

He had just graduated from high school when he came to CVOC to register for the welding program in October of 2004. He was 18 years old, the dependent of a farm worker. He was very eager to learn welding because his uncle is a welder so he wanted to follow his uncle's footsteps. While he was in training, he was very punctual and the instructor was very happy to see how well he did and how eager he was to learn. After completing training, the Job Developer placed him as a welder at Gladden Equipment Erectors. His starting pay was $10.50 per hour and soon after, he began to travel to different States to work for the company. He sometimes spends a month traveling with the company. Today, he still works for the same company and earns $14.00 per hour.

Hugo Sanchez

Hugo had not graduated from high school when he came to CVOC to register for the Cashiering Program in March 2004. He was hoping to obtain his GED, enroll in ESL classes, and obtain a Vocational Training Certificate. While he was attending classroom training, he found the cashiering class was too easy for him so he decided to transfer to General Business Occupations (GBO) training. While in training, he obtained his GED, improved his English skills, and completed GBO training. After completing training, he started working as a temporary data entry teller at E & J Gallo Winery in August of 2004 earning $11.14 per hour. Since this job was temporary, he found another job. In November 2004, he started working at Foster Farms Dairy where he started earning $12.83 per hour. He continues to work for them and now earns $16.97 per hour. In May 2006 he will be making $18.90 per hour as the CAT supervisor

Julian Diaz

Before Julian Diaz came to CVOC, he was working as a farm worker and at Wal-Mart. Julian was living with his parents in Modesto Housing Authority's Public Housing. He wanted to become a welder and he discovered that CVOC offered this training. He saw the CVOC ad in the Modesto Bee and he decided to call. Julian began his 22-week training in welding in September of 2005. He completed his training on February 24, 2006. Even though he finished all his exams in January, Julian decided to stay until February to gain more skills. He was a great student and attended class every day. His instructor was very pleased with his hard work. The instructor even helped him find work.

Julian is now working as a welder at West-Mark in Atwater making $11.00 per hour. He will soon be receiving health benefits and 401k. Julian has achieved all the goals he hoped to achieve and is very happy that he chose CVOC for his training. Julian even went as far as calling the welding instructor in tears on his first day of work to express his gratitude for the training, job skills, tools, and the opportunity that was given to him.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PREPARED STATEMENT OF THE AIDS INSTITUTE

The AIDS Institute, a national public policy research, advocacy, and education organization, is pleased to submit written comments to you in support of a number of critical HIV/AIDS and Hepatitis programs as part of the fiscal year 2007 Labor, Health, and Education and Related Services appropriation measure. We thank you for your consistent support of these programs over the years, and trust you will do your best to adequately fund them in the future in order to provide for, and protect the health of, many Americans.

HIV/AIDS

HIV/AIDS remains one of the world's worst health pandemics in the history of civilization. Worldwide, some 40 million people are infected with this incurable infectious disease, and 14,000 new infections occur each passing day. Tragically, AIDS has already claimed the lives of 25 million people. Here in the United States, ac-

cording to the CDC, 944,305 people have been diagnosed with AIDS, and over 529,000 people have died through 2004. It is estimated there are more than 40,000 new infections in the United States each year. At the end of 2003, an estimated 1,039,000 to 1,185,000 persons in the United States were living with HIV/AIDS.

Persons of minority races and ethnicities are disproportionately affected by HIV/AIDS. In 2003, African Americans, who make up approximately 12 percent of the U.S. population, accounted for half of the HIV/AIDS cases diagnosed. HIV/AIDS also disproportionately affects the poor, and about 70 percent of those infected rely on public health care financing.

The U.S. Government has played a leading role in fighting the AIDS epidemic, both at home and abroad. The vast majority of the discretionary programs supporting HIV/AIDS efforts domestically and a portion of our Nation's contribution to the global AIDS effort are funded through your subcommittee. The AIDS Institute, working in coalition with other AIDS organizations, have developed realistic and practical funding request numbers for each of these domestic and global AIDS programs. The AIDS Institute asks that you do your best to adequately fund these programs at the requested level.

We are keenly aware of the current budget constraints and competing interests for limited Federal dollars. Unfortunately, despite the growing need, almost all domestic HIV/AIDS programs in recent years have experienced funding decreases.

This year, the President has proposed three new domestic HIV/AIDS initiatives by providing $70 million for getting prescription drugs to those who need them; $90 million for testing those who do not yet know their status; and $25 million to help raise the awareness of those who do not know they should be tested. The AIDS Institute applauds these initiatives and encourages the subcommittee to fund these increases.

RYAN WHITE CARE ACT

[In millions of dollars]

Fiscal year	Amount
2005	2,048
2006	2,038
2007 President's request	2,133
2007 community request	2,631

The centerpiece of the Federal Government's response to caring and treating low-income individuals with HIV/AIDS are those programs funded under the Ryan White CARE Act. CARE Act programs currently reach over 571,000 low-income, uninsured, and underinsured people each year, most of who are from a racial or ethnic minority group. The majority of CARE Act funds support primary medical care and essential support services.

Providing care and treatment for those who have HIV/AIDS is not only the compassionate thing to do, but it is cost-effective in the long run, and serves as a tool in prevention of HIV/AIDS.

In recent years, with the exception of minor increases for the AIDS Drug Assistance Program (ADAP), CARE Act funding has decreased. Because of across the board recessions, flat funding has actually resulted in budget cuts for the past several years. We urge you to provide these vitally important programs with the community requested level of funding. Consider the following:

(1) The caseload is increasing. People are living longer with HIV/AIDS due to life-saving medications; there are 40,000 new infections each year; and the Federal Government has initiated increased testing programs to identify positive people-all of which will necessitate the need for more medical services and medications.

(2) There is a greater financial burden on CARE Act programs. The price of healthcare, including medications, is increasing; non-profit organizations are struggling; Medicaid benefits are being scaled-back at the State level and significant Medicaid reductions recently passed the Congress.

(3) Level or decreased funding for the CARE Act is impacting State and local governments grant awards. Because of reduced funding levels, 34 out of the 51 largest cities affected by HIV/AIDS experienced cuts to their Title I awards this year. This is after 18 cities experienced cuts last year. Additionally, 41 States and territories received less money last year in their Title II base awards.

(4) ADAP funding shortfalls are causing States to place clients on waiting lists, limiting drug formularies, and increasing eligibility requirements. In February 2006, nine States reported having waiting lists, totaling 791 people. Several ADAPs re-

ported other cost containment measures, including formulary reductions (4), eligibility restrictions (2) and limiting annual client expenditures (2). Due to the small increase the ADAP program was given last year, additional severe restrictions are anticipated in many additional States across the country.

(5) Two recent reports conclude there are a staggering number of people in the United States who are not receiving life-saving AIDS medications. The Institute of Medicine report "Public Financing and Delivery of HIV/AIDS Care, Securing the Legacy of Ryan White" concluded that 233,069 people in the United States who know their HIV status do not have continuous access to Highly Active Antiretroviral Therapy (HAART). A study by the CDC titled, "Estimated number of HIV-infected persons eligible for and receiving antiretroviral therapy, 2003—United States", reached similar conclusions. According to CDC's estimates, 212,000, or 44 percent of eligible people living with HIV/AIDS, aged 15–49 in the United States, are not receiving antiretroviral therapy. The report concludes, "there is a substantial unmet health care need for antiretroviral therapy among HIV-infected persons in care."

This is a travesty in our own country. As we seek to provide lifesaving medications to those abroad, we must ensure we are providing medications to our own here in the United States.

Fiscal Year 2007 Administration Initiative.—The AIDS Institute is in strong support of President Bush's proposed increase of $70 million for "States in need to bridge the existing gaps in coverage for Americans waiting for life-saving medications. These funds would help the States end current waiting lists and help support care for additional patients." Since ADAP only received a funding increase of $2 million in fiscal year 2006 and the need number for fiscal year 2007 is $197 million, the $70 million increase, while certainly not enough, is a welcome increase. We urge the Committee to approve this long overdue increase.

Additionally, President Bush proposed an increase of additional $25 million Title III Ryan White CARE Act funding "to significantly strengthen outreach by local community and faith-based organizations in hardest hit areas. These grants would help raise awareness, increase early detection, combat stigma, and facilitate access to treatment, especially for African-American, Hispanic, Native American, and other minority community groups whose need is often greatest." This additional funding is also extremely worthy of funding, and the administration should be commended for its proposal.

The AIDS Institute supports continued and increased funding for the Minority HIV/AIDS Initiative (MHAI). MHAI funds services nationwide that address the disproportionate impact that HIV has on communities of color.

CENTERS FOR DISEASE CONTROL AND PREVENTION—HIV PREVENTION AND SURVEILLANCE

[In millions of dollars]

Fiscal year	Amount
2005	662
2006	651
2007 President's request	740
2007 community request	1,049

While the number of new HIV infections in the United States has greatly decreased since the 1980's, there are still an estimated 40,000 new infections each year. Since AIDS is a preventable disease, these are 40,000 new infections annually that could have been prevented. Leading the Federal Government's campaign in AIDS prevention is the CDC. As with other domestic AIDS programs, funding is severely lagging, and the CDC is being asked to do more with fewer and fewer dollars. In fact, CDC's AIDS funding has declined in the last 4 years in a row. It is not surprising given the budget decreases, the administration's goal of reducing the infection rate in half by 2005 did not occur.

Fiscal Year 2007 Administration Initiative.—The AIDS Institute is in strong support of President Bush's proposed increase of $90 million "to the purchase and distribution of rapid HIV test kits, facilitating the testing of more than 3 million additional Americans. Test kits would be distributed in areas of the country with the highest rates of newly discovered HIV cases, and the highest suspected rates of undetected cases." A large portion of the funds would be used for the testing of prisoners and intravenous drug users, two groups with extremely high levels of infections. Knowledge of one's HIV status, particularly for high risk individuals, is an effective prevention tool. Approximately one quarter of the over 1 million people living with HIV in the United States (252,000 to 312,000 persons) are unaware of their

HIV status. This initiative, if funded by the Congress, should help prevent future infections and bring additional people into lifesaving treatment and care. The AIDS Institute urges the Committee to fund this extremely worthy program.

While The AIDS Institute supports increased testing programs, we do not support funding those efforts at the expense of prevention intervention programs. Funding for these programs are already under funded.

We are pleased to hear that the new leadership of CDC's HIV prevention programs has pledged to make the CDC budget more transparent, and will better detail where the funds are being spent, and on what populations and programs. For far too long, this information has not been made available.

Efforts to improve prevention methods and weed out non-effective programs should be a constant undertaking and be guided by science and fact based decision-making. It is for these reasons that The AIDS Institute opposes funding of abstinence-only until marriage programs, for which the President requested a $27 million increase. While we support abstinence-based prevention programs as part of a comprehensive prevention message, there is no scientific proof that abstinence-only programs work. On the contrary, they reject proven prevention tools, such as condoms, and fail to address the needs of homosexuals, who can not marry, and who remain greatly impacted by HIV/AIDS. Given that approximately one-half of all new infections in the United States are among those under the age of 25, it is essential that our youth be given the proper tools to prevent HIV infection.

NATIONAL INSTITUTES OF HEALTH-AIDS RESEARCH

[In million of dollars]

Fiscal year	Amount
2005	2,921
2006	2,903
2007 President's request	2,888
2007 community request	3,000

Through the NIH, research is conducted to: understand the AIDS virus and its complicated mutations; discover new drug treatments; develop a vaccine and other prevention programs such as microbicides; and ultimately, a cure. Much of this work at the NIH is done in cooperation with private funding and ingenuity. The critically important work performed by the NIH not only benefits those in the United States, but the entire world.

This research has already helped in the development of many highly effective new drug treatments, prolonging the lives of millions of people. Undoubtedly, the commitment of the Congress and the administration to double NIH funding over the past 5 years has led to great advances. As neither a cure nor a vaccine exists, and patients continue to build resistance to existing medications, additional research in cooperation with private interests must continue. We are disappointed the President's budget is proposing a decrease of $15 million in AIDS research for fiscal year 2007. We ask the Committee to fund NIH, including critical AIDS research, at the community requested level of $30 billion.

Substance Abuse and Mental Health Services Administration

It is widely known that many persons infected with HIV also experience drug abuse and/or mental health problems, and require the programs funded by SAMHSA. Given the growing need for services, we are disappointed that overall funding requested for SAMHSA is down by $71 million, and the Center for Substance Abuse Treatment is being cut by $24 million, the Center for Substance Abuse Prevention is cut by $12 million, and the Center for Mental Health Services is cut by $35 million. We ask the Committee to reject these cuts, and adequately fund these programs.

VIRAL HEPATITIS

Viral Hepatitis, whether A, B, or C, are infectious diseases that also deserve special attention by the Federal Government and the subcommittee. According to the CDC, there are an estimated 1.25 million Americans chronically infected with Hepatitis B, and 73,000 new infections each year. Although there is no cure, a vaccine has been available since 1982, and there are a few treatment options available. An estimated 3.9 million (1.8 percent) Americans have been infected with Hepatitis C, of whom 2.7 million are chronically infected. Currently, there is no vaccine or cure,

and very few treatment options available. It is believed that one-third of those infected with HIV are co-infected with Hepatitis C.

Given these numbers, we are disappointed that the administration is proposing to cut the 317 Immunization Grant Program funds that serve as the major source in the public sector for at-risk adult immunizations. Instead of facing cuts, since the vaccines are relatively inexpensive, this cost-effective program should be significantly enhanced in order to protect people from Hepatitis A and B. We recommend funding the 317 Program at $800 million for fiscal year 2007 in order to fully realize the public health benefits of immunization.

The administration is also calling for decreased funding for Viral Hepatitis at the CDC. The program is currently funded at a level less than it was in fiscal year 2003, and falls way short of the $50 million that is needed. These funds are needed to establish a program to lower the incidence of Hepatitis C through education, outreach, and surveillance, and to support such initiatives as the CDC National Hepatitis C Prevention Strategy and the 2002 NIH Consensus Statement on the Management of Hepatitis C and accompanying recommendations.

The AIDS Institute asks that you give great weight to our testimony and remember it as you deliberate over the fiscal year 2007 appropriation bill. Should you have any questions or comments, feel free to contact Carl Schmid, Director of Federal Affairs, The AIDS Institute (202) 462–3042 or cschmid@theaidsinstitute.org. Thank you very much.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

The 94,000-member American Academy of Family Physicians submits this statement for the record to the Senate Appropriations Subcommittee on Labor/Health and Human Services, Education and Related Agencies. Our statement is made in support of the Section 747 Primary Care Medicine and Dentistry Cluster. The Academy also supports the Agency for Healthcare Research and Quality (AHRQ) and rural health programs.

BRIEF BACKGROUND: TRAINING FAMILY PHYSICIANS

Section 747 within the Public Health Service Act is the only Federal program that funds training for family physicians. The law requires the program to meet two goals: (1) increase the number of primary care physicians (family physicians, general internists and general pediatricians) and (2) boost the number of people to provide care to the underserved. Regarding family medicine specifically, Section 747 offers competitive grants for training programs in medical school and in residency programs.

The fiscal year 2006 spending bill provided $41 million to Section 747, a figure that was a significant cut from the $88.8 million the cluster received in fiscal year 2005. And, unfortunately, the President's fiscal year 2007 budget proposed zero dollars for the program. We urge Congress to fund Section 747 at fiscal year 2005 levels ($88.8 million).

WHO ARE FAMILY PHYSICIANS?

Family physicians are the specialists trained to provide comprehensive, coordinated and continuing care to patients of both genders and all ages and ethnicities, regardless of medical condition. These residency-trained, primary care physicians treat babies with ear infections, adolescents who are obese, adults with depression and seniors with multiple, chronic illnesses. And because they focus on prevention, primary care, and integrating care for their patients, they are able to treat illnesses early and cost-effectively. In addition, when necessary, family physicians help patients navigate our complex health system and find the right subspecialists. Finally, family physicians are distributed throughout the country in approximately the same proportion as the population: about one-quarter of all Americans live in rural areas and about 25 percent of family physicians practice there, as well.

COMMUNITY HEALTH CENTERS: UNDERSTAFFED WITH SHORTAGES OF FAMILY PHYSICIANS

Over the last few years, the administration has made increasing the number of Community Health Centers (CHCs) a priority within its health care budget. Specifically, the President's fiscal year 2007 blueprint recommends an increase of $181 million for CHCs, which would increase funding to nearly $2 billion. These dollars would complete the administration's goal to create 1,200 health center sites around the Nation. While a laudable objective, this funding does not take into account staff-

ing issues at these centers; the CHC dollars go primarily to so-called "bricks and mortar," i.e., construction of the health care clinics.

The additional funding recommended in the President's budget to build Community Health Centers, and the zero dollars proposed to train family physicians under Section 747, are a serious disconnect: primary care physicians make up nearly 90 percent of doctors working in CHCs—and most are family physicians. In short, without more family physicians, no one will be available to staff these new centers.

This point was brought home in a March 1, 2006 article in the Journal of the American Medical Association (JAMA). The authors found that in 2004, CHCs were understaffed and could not fill all clinical positions (Rosenblatt, et al.). Rural health centers had more openings that took longer to fill than those in urban areas. More alarmingly, over 13 percent of family physician positions at CHCs were vacant.

As the only Federal program that trains family physicians, funding for Section 747 is critical. Without Section 747 to train family physicians, CHCs staffing problems will get worse.

SECTION 747 PRODUCES DOCTORS WHO WORK IN CHCS AND SERVE IN THE NHSC

A second study buttresses the importance of family physicians to CHCs and to the National Health Service Corps, which is another administration priority. An unpublished 2006 study from the University of California, San Francisco and the Robert Graham Center for Policy Studies in Family Medicine and Primary Care shows that medical schools that receive Section 747 dollars produce physicians who work in CHCs and serve in the National Health Service Corps compared to schools without this funding.

The finding is particularly true for family physicians. Specifically, according to the study, nearly 4,000 family physicians and general practitioners were exposed to Title VII funding during medical school and subsequently chose to work in a CHC. Without this exposure, at least 750 fewer family physicians would have been working in a CHC in 2003. Coupled with the JAMA article, which shows that there are 600 vacancies for family physicians, without Section 747 funding, there would be twice as many vacancies in health centers.

LOWER HEALTH CARE COSTS AND IMPROVED QUALITY

Section 747 plays a role in lowering our Nation's health care costs and increasing the quality of U.S. health care. For example, an article in Health Affairs (April 2004) demonstrated that States that spent more on Medicare had lower quality of care. While seemingly counterintuitive, the authors found two reasons for this result.

The first reason was that expensive health care did not improve patient satisfaction or outcomes. The second reason was that the makeup of the health care workforce made a difference: more primary care doctors in a State meant higher quality care and lower cost. In contrast, more specialists and fewer generalists led to lower quality and higher costs. And, just a small increase in the number of primary care doctors in a State was associated with a large boost in that State's quality ranking.

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An article in a March 2005 edition of Health Affairs, "The Effects of Specialist Supply on Populations' Health: Assessing the Evidence" went even further. This piece stated that there was a "negative relationship between the supply of primary care physicians and death from stroke, infant mortality and low-birthweight, and all-cause mortality." The article went on to say that just one more primary care physician per 10,000 people was associated with a decrease of 34.6 deaths per 100,000 people.

The article also cited breast cancer research for the State of Florida, which indicated that "each tenth-percentile increase in primary care physician supply is associated with a statistically significant 4 percent increase in odds of early-stage breast cancer." Statistics were similar for other types of cancers: there was a relationship between early identification of cancer and the supply of primary care physicians. Numerous other research was highlighted in the Health Affairs article that indicated a higher ratio of primary care physicians to populations led to better health outcomes. These data support the need for additional funding for Section 747, the only Federal program that produces primary care physicians.

THE OVERSPECIALIZED U.S. PHYSICIAN WORKFORCE: A WORLD ANOMALY

Unlike all other developed countries, the United States does not have a primary care-based health care system. While other developed countries have about equal numbers of primary care physicians and subspecialists, in the United States, less than one-third of the physician workforce is primary care.

More disturbingly, compared to developed countries, the United States spends the most per capita on healthcare—but has some of the worst healthcare outcomes. More than 20 years of evidence have shown that a health system based on primary care produces greater health and economic benefits. Boosting support for Section 747, which funds training for family physicians and for other primary care disciplines, could improve the health of patients in the United States.

AGENCY FOR HEALTHCARE, RESEARCH AND QUALITY

The Academy recommends $440 million for the Agency for Healthcare, Research and Quality (AHRQ). A major purpose of AHRQ is to conduct primary care and health services research geared to physician practices, health plans and policymakers. What this means is that the agency translates research findings from basic science entities like the National Institutes of Health (NIH) into information that doctors can use every day in their practices. Another key function of the agency is to support research on the conditions that affect most Americans.

More recently, AHRQ has become the lead Federal agency for research on comparative clinical effectiveness; information technology; and patient safety. For example, the Medicare Modernization Act asked AHRQ to study the "clinical effectiveness and appropriateness of specified health services and treatments," and to use this information to improve the quality and effectiveness of the costly Medicare, Medicaid and SCHIP programs. In fiscal year 2006, $15 million was appropriated by Congress for this purpose. This type of study on "what works" in clinical therapies is crucial in an era of skyrocketing health care costs and limited Federal dollars.

Historically, however, AHRQ has been the lead agency to translate research into information for physicians and patients. Over the years, Congress has provided billions of dollars to the National Institutes of Health, which has resulted in important insights in preventing and curing major diseases. However, AHRQ's role has been to take this basic science and produce understandable, practical materials for the entire healthcare system. In short, AHRQ is the link between research and the patient care that Americans receive.

In addition, AHRQ has long-supported research on conditions that affect most people. Most Americans get their medical care in doctors' offices and clinics. However, most medical research comes from the study of extremely ill patients in hospitals. AHRQ studies and supports research on the types of illness that trouble most people. In brief, AHRQ looks at the problems that bring people to their doctors every day—not the problems that send them to the hospital.

RURAL HEALTH PROGRAMS

Continued funding for rural programs is vital to provide adequate health care services to America's rural citizens. We support the Federal Office of Rural Health Policy; Area Health Education Centers; the Community and Migrant Health Center Program; and the NHSC. State rural health offices, funded through the National Health Services Corps budget, help States implement these programs so that rural residents benefit as much as urban patients.

CONCLUSION

The Academy urges Congress to fund Section 747 at fiscal year 2005 levels ($88.8 million). We believe that the two recent studies showing that Community Health Centers not only rely heavily on family physicians, but cannot fill all of their positions, and the data indicating the crucial role that primary care training plays in whether physicians practice in CHCs or serve in the NHSC, make an irrefutable case for funding Section 747. In addition, however, family physicians are critical to the health and well-being of everyone in the country. Finally, all of these studies, authored by different researchers, are consistent: Section 747 works.

The AAFP also urges Congress to fund the Agency for Healthcare Research and Quality at $440 million; and support rural health programs. We thank you in advance for making these investments in America's healthcare system.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF PEDIATRICS

There can be no denying that there have been numerous and significant successes in improving the health and well-being of America's children and adolescents, from even just decades ago. Infant and child mortality rates have been radically lowered. The number of 2-year-olds who have received the recommended series of immunizations is at an all-time high, while vaccine-preventable diseases such as measles, pertussis, and diphtheria have decreased by over 98 percent Teen pregnancy rates have declined by 27 percent over the last decade. Still, despite these successes, far too many children in America continue to suffer from disease, injury, abuse, racial and ethnic health disparities, or lack of access to quality care. And more than 9 million children and adolescents through age 18 remain uninsured. Clearly there remains much work to do.

As clinicians we not only diagnose and treat our patients, we must also promote strong preventive interventions to improve the overall health and well-being of all infants, children, adolescents and young adults. Likewise, as policy-makers, you have an integral role to play in improving the health of the next generation through adequate and sustained funding of vital Federal programs.

The AAP, SAM and APA have identified three key priorities within this Committee's jurisdiction that are at the heart of improving the health and well-being of America's children and adolescents: access to health care, quality of health care, and immunizations.

ACCESS

We believe that all children and adolescents should have full access to comprehensive, age-appropriate, quality health care. From the ability to receive primary care from a pediatrician trained in the unique needs of children and adolescents, to timely access, to pediatric medical subspecialists and pediatric surgical specialists, America's children and adolescents deserve access to quality pediatric care in a medical home. Given the recent cuts to the Medicaid program and fiscal belt-tightening in the States, discretionary programs now more than ever provide a vital health care safety net for America's most vulnerable children and adolescents.

Maternal and Child Health Block Grant.—The Maternal and Child Health (MCH) Block Grant Program at the Health Resources and Services Administration (HRSA) is the only Federal program exclusively dedicated to improving the health of all mothers and children. Nationwide, the MCH Block Grant Program provides preventive and primary care services to over 32 million women, infants, children, adolescents and children with special health care needs. In addition, the MCH Block Grant Program supports community programs around the country in their efforts to reduce infant mortality, prevent injury and violence, expand access to oral health care, and address racial and ethnic health disparities. Moreover, the MCH Block Grant Program includes efforts dedicated to addressing interdisciplinary training, services and research for adolescents' physical and mental health care needs, and supports programs for vulnerable adolescent populations, including health care initiatives for incarcerated and minority adolescents, and violence and suicide prevention. It also plays an important role in the implementation of the State Children's Health Insurance Program (SCHIP), which is critically important at a time when States are struggling with ongoing deficits and shifting costs. One of the many successful MCH Block Grant programs is the Healthy Tomorrows Partnership for Children Program, a public/private collaboration between the MCH Bureau and the American Academy of Pediatrics. Established in 1989, Healthy Tomorrows has supported over 140 family-centered, community-based initiatives in 44 States, including Ohio, Wisconsin, Texas, California, Kentucky, Rhode Island, and Maryland. These initiatives have addressed issues such as access to oral and mental health care, abstinence, injury prevention, and enhanced clinical services for chronic conditions such as asthma. To continue to foster these and other community-based solutions for local health problems, in fiscal year 2007 we strongly support an increase in funding for the MCH Block Grant Program to $724 million.

Family Planning Services.—The family planning program, Title X of the Public Health Services Act, ensures that all teens have confidential access to valuable family planning resources. For every dollar spent on family planning through Title X, $3 is saved in pregnancy-related and newborn care costs to Medicaid. Title X—which does not provide funding for abortion services—provides critically needed preventive care services like pap tests, breast exams, and STI tests to millions of adolescents and women. But funding for Title X continues to fall well below the need. Over 9 million cases of STIs (almost half the total number) are in 15- to 24-year-olds, and over 30 percent of women will become pregnant at least once before age 20. Teen pregnancy rates continue to vary over racial and ethnic groups, and nearly

half (48 percent) of all teens say that they want more information from—and increased access to—sexual health care services. Responsible sexual decision-making, beginning with abstinence, is the surest way to protect against sexually transmitted infections and pregnancy. However, for adolescent patients who are already sexually active, confidential contraceptive services, screening and prevention strategies should be available. We therefore support a funding level in fiscal year 2007 of $375 million for Title X of the Public Health Service Act.

Mental Health.—It is estimated that over 13 million children and adolescents have a mental health problem such as depression, ADHD, or an eating disorder, and for as many as 6 million this problem may be significant enough to disturb school attendance, interrupt social interactions, and disrupt family life. Despite these statistics, the National Institute of Mental Health (NIMH) estimates that 75–80 percent of these children fail to receive mental health specialty services, due to stigma and the lack of affordability of care and availability of specialists. Grants through the Children's Mental Health Services program have been instrumental in achieving decreased utilization of inpatient services, improvement in school attendance and lower law enforcement contact for children and adolescents. We recommend that $109.7 million be allocated in fiscal year 2007 for the Mental Health Services for Children program to continue these improvements for children and adolescents with mental health problems.

Child Abuse and Neglect.—Health care providers play a crucial role in the prevention, identification, and treatment of child abuse and neglect. In spite of this fact, few Federal resources are dedicated to bringing the medical profession into full partnership with law enforcement, the judiciary, and social workers. We urge the subcommittee to provide an increase of $10 million in fiscal year 2007 for the Center for Disease Control and Prevention's National Center for Injury Prevention and Control to establish a network of consortia to link and leverage health care professionals and resources to address—and ultimately prevent—child abuse and neglect.

Health Professions Education and Training.—Critical to building a pediatric workforce to care for tomorrow's children and adolescents are the Training Grants in Primary Care Medicine and Dentistry, found in Title VII of the Public Health Service Act. These grants are the only Federal support targeted to the training of primary care professionals. They provide funding for innovative pediatric residency training, faculty development and post-doctoral programs throughout the country. For example, the Montefiore Medical Center in the South Bronx of New York City has used Title VII funds to support its Residency Training Program in Social Pediatrics (RPSP). Initiated in response to local needs to prepare physicians for the delivery of care to underserved populations and to practice specifically at Community Health Centers in the inner-city setting, RPSP simultaneously trains physicians in neighborhood health centers and in an academic hospital. Since its inception, RPSP has graduated over one hundred pediatricians, a large number of whom are women and minority physicians. Additionally, 79 percent of all RPSP graduates report that they currently practice in community-oriented primary care settings serving predominately poor and minority inner-city populations. Another 10 percent of RPSP graduates report that they are involved in professional activities such as health administration and policy, including directing patient care in community health centers.

Through the continuing efforts of this subcommittee, Title VII has provided a vital source of funding for critically important programs that educate and train tomorrow's generalist pediatricians in a variety of settings to be culturally competent and to meet the special health care needs of their communities. We recommend fiscal year 2007 funding of at least $40 million for General Internal Medicine/General Pediatrics. We also join with the Health Professions and Nursing Education Coalition in supporting an appropriation of at least $550 million in total funding for Titles VII and VIII. We applaud the administration's support for the National Health Service Corps and Community Health Centers, key components with Title VII to ensuring an adequate distribution of health care providers across the country; but we emphasize the need for continued support of the training and education opportunities through Title VII for health care professionals who provide care for our Nation's communities.

Independent Children's Teaching Hospitals.—Equally important to the future of pediatric education and research is the dilemma faced by independent children's teaching hospitals. In addition to providing critical care to the Nation's children, independent children's hospitals play a significant role in training tomorrow's pediatricians and pediatric subspecialists. Children's hospitals train 30 percent of all pediatricians, half of all pediatric subspecialists, and the majority of pediatric researchers. However, children's hospitals qualify for very limited Medicare support, the primary source of funding for graduate medical education in other inpatient en-

vironments. As a bipartisan Congress has recognized in the last several years, equitable funding for Children's Hospitals Graduate Medical Education (CHGME) is needed to continue the education and research programs in these child- and adolescent-centered settings. Since 2000, CHGME hospitals accounted for nearly 87 percent of the growth in pediatric subspecialty training programs and 68 percent of the growth in pediatric subspecialty fellows trained. We are extremely disappointed in the 67 percent reduction in funding for this vital program proposed by the administration, and join with the National Association of Children's Hospitals to restore funding of $303 million for the CHGME program in fiscal year 2007. The support for independent children's hospitals should not come, however, at the expense of valuable Title VII and VIII programs, including grant support for primary care training.

QUALITY

Access to health care is only the first step in protecting the health of all children and adolescents. We must ensure that the care provided is of the highest quality. Robust Federal support for the wide array of quality improvement initiatives, including research, is needed if this goal is to be achieved.

Emergency Services for Children.—One program that assists local communities in providing quality care to children in distress is the Emergency Medical Services for Children (EMSC) grant program. There are approximately 30 million child and adolescent visits to the Nation's emergency departments every year. Children under the age of 3 years account for most of these visits. Up to 20 percent of children needing emergency care have underlying medical conditions such as asthma, diabetes, sickle-cell disease, low birthweight, and bronchopulmonary dysplasia. A CDC report issued in February of 2006 reaffirmed that more hospitals must be properly equipped and clinicians must be educated and trained to manage these special health care needs in emergency situations. In addition, emergency systems must be equipped with the resources needed to care for this especially vulnerable population. In order to assist local communities in providing the best emergency care to children, we once again reject the administration's proposed elimination of the EMSC program and strongly urge that the EMSC program be maintained and adequately funded at $25 million in fiscal year 2007.

Agency for Healthcare Research and Quality.—Quality of care rests on quality research—for new detection methods, new treatments, new technology and new applications of science. As the lead Federal agency on quality of care research, the Agency for Healthcare Research and Quality (AHRQ) provides the scientific basis to improve the quality of care, supports emerging critical issues in health care delivery and addresses the particular needs of priority populations, such as children. Substantial gaps still remain in what we know about health care needs for children and adolescents and how we can best address those needs. Children are often excluded from research that could address these issues. The AAP and endorsing organizations strongly support AHRQ's objective to encourage researchers to include children and adolescents as part of their research populations. We also support increasing AHRQ's efforts to build pediatric health services research capacity through career and faculty development awards and strong practice-based research networks. Additionally, AHRQ is focusing on initiatives in community and rural hospitals to reduce medical errors and to improve patient safety through innovative use of information technology—an initiative that we hope would include children's hospitals as well. Through its research and quality agenda, AHRQ continues to provide policymakers, health care providers, and patients with critical information needed to improve health care; therefore, we join with the Friends of AHRQ to recommend funding of $440 million for AHRQ in fiscal year 2007.

National Institutes of Health.—Since its inception, the National Institutes of Health (NIH) has been an integral part of the public health continuum. NIH serves as a vital component in improving the Nation's health through research, both on and off the NIH campus, and in the training of researchers, including pediatric investigators. Over the years, NIH has made dramatic strides that directly impact the quality of life for infants, children and adolescents through biomedical and behavioral research. For example, NIH research has led to successfully decreasing infant death rates by over 70 percent, increasing the survival rates from respiratory distress syndrome, and dramatically reducing the transmission of HIV from infected mother to fetus and infant from 25 percent to just 1.5 percent. NIH is engaged in a comprehensive research initiative to address and explain the reasons for a major public health dilemma—the increasing number of obese and overweight children and adults in this country. Today U.S. teenagers are more overweight than young people in many other developed countries. And the Newborn Screening Initiative is

moving forward to improve availability, accessibility, and quality of genetic tests for rare conditions that can be uncovered in newborns. The pediatric community applauds the prior commitment of Congress to maintain adequate funding for the NIH. We remain concerned, however, that the cumulative effect of several years of flat funding will stall or even set back the gains that were made under the years of the NIH's budget doubling. We urge you to sustain the momentum of scientific discovery. We support the recommendation of the Ad Hoc Group for Medical Research for a funding level in fiscal year 2007 of $29.75 billion. In addition, to ensure ongoing and adequate child and adolescent focused research, such as the National Children's Study (NCS) led by the National Institute for Child Health and Human Development (NICHD), we join with the Friends of NICHD Coalition in requesting $1.35 billion in fiscal year 2007. Moreover we recommend that the NCS be adequately funded in fiscal year 2007 at $69 million to begin the implementation phase of this important study. We are greatly disappointed by and reject the administration's proposal to phase out the NCS in 2007. This large longitudinal study, authorized in the Children's Health Act of 2000, will provide critical research and information on major causes of childhood illnesses such as premature birth, asthma, obesity, preventable injury, autism, development delay, mental illness, and learning disorders.

We commend this committee's ongoing efforts to make pediatric research a priority at the highest level of the NIH. We urge continued Federal support of NIH efforts to increase pediatric biomedical and behavioral research, including such proven programs as targeted training and education opportunities and loan repayment. We recommend continued interest in and support for the Pediatric Research Initiative in the Office of the NIH Director and sufficient funding to continue the pediatric training grant and pediatric loan repayment programs both enacted in the Children's Health Act of 2000. This would ensure that we have adequately trained pediatric researchers in multiple disciplines that will not come at the expense of other important programs.

Finally, as clinicians, we know first-hand the considerable benefits for children and society in securing properly studied and dosed medications. The benefits of pediatric drug testing are undisputed. Proper pediatric safety and dosing information reduces medical errors and adverse events, ultimately improving children's health and reducing health care costs. In a very conservative estimate, the FDA projects savings from pediatric testing of over $228 million a year in reduced hospitalization expenses for just five diseases affecting children. But until now there has been little incentive for drug companies to study off-patent drugs—older drugs that are critically needed therapies for children. The Research Fund for the Study of Drugs, created as part of the Best Pharmaceuticals for Children Act of 2002, provides support for these critical pediatric testing needs, but unfortunately is currently funded at an amount sufficient to test only a fraction of the NIH and FDA-designated "priority" drugs. Therefore, we urge the subcommittee to provide the NIH with sufficient funding to fund the study of generic (off-patent) and selected on-patent drugs for pediatric use.

We believe that these requests represent the best and most reliable estimates of the level of funding needed to sustain the high standard of scientific achievement embodied by the NIH. However, we encourage Congress to explore all possible options to identify additional sources of funding needed to support these increases if we are to reach these funding goals while not weakening any other valuable component of the Public Health Service.

IMMUNIZATION

Immunization remains one of the greatest public health achievements of the last century, saving literally millions of lives. Thanks to the widespread use of vaccines, millions of children have avoided serious and often fatal diseases that previously devastated lives. Before immunization, polio paralyzed 10,000–25,000 children and adults, rubella (German measles) caused birth defects and mental retardation in as many as 20,000 newborns, and measles infected millions of children, killing 400–500 and leaving thousands with serious brain damage each year. Immunizations have reduced by more than 95 percent the cases of vaccine-preventable infectious diseases in this country. And some, like rubella, are virtually eliminated from North America, thanks to successful immunization programs.

Pediatricians, working alongside public health professionals and other partners, have brought the United States its highest immunization coverage levels in history—over 92 percent of children received all vaccinations by school age in 2004–2005. We attribute this, in part, to the Vaccines for Children (VFC) Program, and encourage Congress to maintain its commitment to ensuring the program's viability.

The VFC program combines the efforts of public health and private pediatricians and other health care professionals to accomplish and sustain vaccine coverage goals for both today's and tomorrow's vaccines. It removes vaccine cost as a barrier to immunization for some and reinforces the concept of vaccine delivery in a "medical home." However, we are concerned that the administration's fiscal year 2007 budget once again has proposed to reduce funding for the Section 317 program by transferring funds from that program to expand VFC. This is shortsighted. Additional section 317 funding is necessary to provide the pneumococcal conjugate vaccine (PCV–7), a vaccine that prevents an infection of the brain covering, blood infections and approximately 7 million ear infections a year, to those remaining States that currently do not provide it. Increased Section 317 funding also is needed to purchase the influenza vaccine—now recommended for children between the ages of 6 months and 5 years of age. This age cohort is increasingly susceptible to serious infection and the risk of hospitalization. And an increase in funding is needed to purchase the recently recommended rotavirus vaccine, tetanus-diptheria-pertussis (Tdap) vaccine for adolescents and the meningococcal conjugate vaccine (MCV). Meningococcal disease is a serious illness, caused by bacteria, with 10–15 percent of cases fatal and another 10–15 percent of cases resulting in permanent hearing loss, mental retardation, or loss of limbs.

The public health infrastructure that now supports our national immunization efforts must not be jeopardized with insufficient funding. One of the conclusions of the 2000 Institute of Medicine report, Calling the Shots, was that unstable funding for State immunization programs threatens coverage levels for specific populations and age groups and vaccine safety. This continues to be true today. A strong and sufficient infrastructure is essential. For example, adolescents continue to be adversely affected by vaccine-preventable diseases (e.g., chicken pox, hepatitis B, measles and rubella). Comprehensive adolescent immunization activities at the national, State and local levels are needed to achieve national disease elimination goals. States and communities continue to be financially strapped and therefore, many continue to divert funds and health professionals from routine immunization clinics in order to accommodate anti-bioterrorism initiatives or now pandemic influenza. Moreover, continued investment in the CDC's immunization activities must be made to avoid the reoccurrence of childhood vaccine shortages by providing and adequately funding a national 6 month stockpile for all routine childhood vaccines—stockpiles of sufficient size to insure that significant and unexpected interruptions in manufacturing do not result in shortages for children.

While the ultimate goal of immunizations clearly is eradication of disease, the immediate goal must be prevention of disease in individuals or groups. To this end, we strongly believe that CDC's efforts must be sustained. In fiscal year 2007, we recommend an overall increase in funding above fiscal year 2006 of $282 million to ensure that the CDC's National Immunization Program has the funding necessary to accommodate vaccine price increases, new disease preventable vaccines coming on the market, global immunization initiatives—including funds for polio eradication and the elimination of measles and rubella—and to continue to implement the recommendations developed by the IOM.

CONCLUSION

We appreciate the opportunity to provide our recommendations for the coming fiscal year. As this subcommittee is once again faced with difficult choices and multiple priorities we know that as in the past years, you will not forget America's children and adolescents.

Other recommendations for fiscal year 2007:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency	Amount
Centers for Disease Control and Prevention (total)	$8,500,000,000
Polio Eradication	101,254,000
Birth Defects, Disability and Health	135,000,000
Newborn Hearing Screening Technical Assistance	9,000,000
National Violent Death Reporting System	10,000,000
Folic Acid Education Campaign	4,000,000
Health Resources and Services Administration (total)	7,500,000,000
Newborn Hearing Screening Grants to States	10,000,000
Consolidated Community Health Centers	2,038,000,000
Substance Abuse and Mental Health Services Administration (total)	3,531,000,000
Indian Health Service (total)	3,361,000,000

DEPARTMENT OF HEALTH AND HUMAN SERVICES—Continued

Agency	Amount
Food and Drug Administration (total)	1,566,000,000

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF NURSING

The American Association of Colleges of Nursing (AACN) respectfully submits this statement highlighting funding priorities for nursing education and research programs in fiscal year 2007. AACN represents over 590 senior colleges and universities with baccalaureate and graduate nursing programs that include over 210,000 students and 11,000 faculty members. These institutions are responsible for educating almost half of our Nation's registered nurses (RNs) and all of the nurse faculty and researchers. Nursing represents the largest health profession, with approximately 2.9 million dedicated, trusted professionals delivering primary, acute, and chronic care to millions of Americans.

THE NATIONWIDE NURSING SHORTAGE

Our country continues to be challenged by a shortage of registered nurses that was first noted in 1998. This shortage is showing no signs of diminishing and demographics reveal that, unlike shortages in the past, it will affect health care delivery for the foreseeable future. In 2005, the American College of Healthcare Executives reported that 85 percent of hospitals experienced a nursing shortage. The U.S. Bureau of Labor Statistics (BLS) has projected that our country will require an additional 1.2 million new and replacement registered nurses by 2014. Nursing has been identified by BLS as the fastest growing professional occupation in the country. However, according to the Health Resources and Services Administration (HRSA), the supply of RNs will drop 29 percent below demand by 2020 unless deliberate action is taken to increase the number of nurses graduating each year and entering the workforce. Nursing vacancies exist throughout all health care sectors, including long-term care, home care, and public health. Among the Nation's 5,000 community health centers, the vacancy rate for RNs is 10 percent and 9 percent for nurse practitioners. Even the Department of Veterans Affairs, the largest sole employer of RNs in the United States, has a 10 percent RN vacancy rate.

Research clearly documents that patient safety is compromised without a sufficient number of RNs. In 2002, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) noted that the nursing shortage contributed to nearly a quarter of all unexpected incidents that adversely affect hospitalized patients. Since RNs comprise the largest component of a hospital workforce, shortages result in emergency room overcrowding and diversions, increased wait time for or cancellation of surgeries, discontinued patient care programs or reduced service hours, and delayed discharges.

The nursing shortage also threatens homeland security and disaster preparedness efforts. The Government Accountability Office reported that local and State health officials cited the nursing shortage as an impediment to their preparedness efforts in 2003.

These alarming facts are coupled with little change in contributing factors, such as the aging of America's population, the aging nurse workforce, high rates of RN retirement, and the increasing demand for high acuity health care services by chronically ill, medically complex patients. To ensure that every patient receives the safest, highest quality health care, Federal support must continue to play an integral role in our Nation's efforts to address the nursing shortage.

CURRENT STRATEGY: NURSING WORKFORCE DEVELOPMENT PROGRAMS

Acknowledging the severity of the Nation's nursing shortage, Congress passed The Nurse Reinvestment Act of 2002. This legislation created new programs and expanded existing Nursing Workforce Development authorities. Administered by HRSA under Title VIII of the Public Health Service Act, these programs focus on the supply and distribution of RNs across the country. Programs support individual students in their nursing studies through loans, scholarships, and loan repayment programs. Title VIII programs stimulate innovation in nursing practice and bolster nursing education throughout the continuum, from entry-level preparation through graduate study. They are the largest source of Federal funding for nursing education assisting students, schools of nursing, and health systems in their efforts to

educate, recruit, and retain RNs. In fiscal year 2005, these programs helped to educate 52,759 student nurses through individual and programmatic support.

Funding for these authorities is insufficient to address the severity of the nursing shortage. Currently, Nursing Workforce Development Programs receive $149.68 million, down from $150.67 million in fiscal year 2005. During the nursing shortage in 1974, Congress appropriated $153 million for nursing education programs. Translated into today's dollars, that appropriation would total $615 million, more than four times the current level. However, it will take billions of dollars to resolve today's nursing shortage.

AACN respectfully requests $175 million for Title VIII Nursing Workforce Development in fiscal year 2007, an additional $25.32 million over fiscal year 2006. New monies would expand nursing education, recruitment, and retention efforts to help resolve the nursing shortage.

Colleges of Nursing Respond

The approximately 1,500 schools of nursing nationwide have been working diligently to expand enrollments. AACN's 2005–2006 annual survey of 567 schools entitled, Enrollments and Graduations in Baccalaureate and Graduate Programs in Nursing, reveals that enrollments increased by 9.7 percent in entry-level baccalaureate nursing programs. This makes the fifth consecutive year of enrollment increases that can be attributed to a combination of Federal support through Nursing Workforce Development Programs, private sector marketing efforts, public-private partnerships providing additional resources to expand capacity of nursing programs, and State legislation targeting funds towards nursing scholarships and loan repayment.

While impressive, these increases still cannot meet the demand. In the November 2003 issue of Health Affairs, Dr. Peter Buerhaus reported that nursing school enrollments would have to increase by at least 40 percent annually just to replace those nurses who retire. Despite intensive efforts nationwide, AACN found that enrollments increased by a total of 57.2 percent, over the last 5 years in entry-level baccalaureate programs. Moreover, only 8.1 percent of RNs are under the age of 30, according to the 2004 National Sample Survey of Registered Nurses.

Despite increasing enrollments and the escalating demand for RNs, U.S. schools of nursing still are forced to turn away eligible students. At least 41,683 qualified applications were turned away despite the increase in enrollments. This is a 27 percent increase from the over 32,797 denied admission in 2004, according to AACN data. Reasons cited for this denial are insufficient numbers of faculty, clinical sites, classroom space, clinical preceptors, and budget constraints. Over 73 percent of the schools surveyed cited the faculty shortage as the primary barrier to increasing enrollments. Some of these qualified students are placed on waiting lists for 2 years or more, but many good students are lost to the nursing profession.

Bottleneck: The Nurse Faculty Shortage

AACN believes that the most effective strategy to resolve the nursing shortage is addressing the underlying faculty shortage. HRSA reported in 2004 that just 13 percent of the RN workforce holds either a master's or doctoral degree, credentials required to teach. In 2003, there were 10,500 full-time masters and doctorally prepared faculty in baccalaureate and graduate nursing programs. Projections through 2012 show that the faculty pool will shrink by at least 2,000 as compared to 2003, even after accounting for retirements, resignations, and additional entrants. Note that these figures do not take into account the need for faculty in new or expanded programs, but only represent present staffing requirements. If the faculty vacancy rate holds steady, the deficit of nurse faculty is expected to swell to over 2,600 unfilled positions in 2012.

This situation will only worsen with time. The number of productive years for nurse educators will decrease as faculty age continues to climb, averaging 52 years in 2004. As such, significant numbers of faculty are expected to retire in the coming years, but there are not enough candidates in the pipeline to take their places. An average of 410 individuals are awarded doctoral degrees in nursing each year, but almost a quarter (23 percent) take jobs outside of academic nursing. In 2005, AACN found a faculty vacancy rate of 8.5 percent, which translates into an average of approximately 2 faculty vacancies per school of nursing. Of those vacancies, over half, (52.6 percent) required a doctoral degree. Higher compensation in clinical and private sector settings lures current and potential nurse educators away from the classroom. For example, the average salary of a nurse practitioner in an emergency department was $84,835, according to the 2005 National Salary Survey of Nurse Practitioners. However, the average salary for a nurse practitioner in academia was

only $66,925, 26.8 percent less. Without sufficient nurse faculty, schools of nursing cannot expand enrollments.

Reversing the Trend: Nurse Faculty Loan Program (Sec. 846A).—This trend can be reversed with additional appropriations for the Nurse Faculty Loan Program. Designed to increase the number of nurse faculty, schools of nursing receive grants to create a loan fund. To be eligible for these loans, students must pursue full-time study for a masters or doctoral degree. In exchange for teaching at a school of nursing, loan recipients will have up to 85 percent of their educational loans cancelled over a 4-year period. A student may receive a maximum loan award of $30,000 per academic year for tuition, books, fees, laboratory expenses, and other reasonable. educational costs. In fiscal year 2005, 66 new grants were made to schools of nursing, and 26 grants were continued, totaling 92. These funds will support an estimated 475 future nurse faculty members. In fiscal year 2006, $4.77 million was appropriated. However, if the current funding was doubled to almost $10 million, based on fiscal year 2005 projections, colleges of nursing could educate over 900 future faculty. Further, with an average faculty to student ratio of 1:10, those 900 faculty could teach an additional 9,000 nurses each year.

Advanced Education Nursing Program (Sec. 811).—These grants support the majority of schools of nursing preparing graduate-level nurses, some of whom become faculty. Receiving $57.06 million in fiscal year 2006, this grant program helps schools of nursing, academic health centers, and other nonprofit entities improve the education and practice of nurse practitioners, nurse-midwives, nurse anesthetists, nurse educators, nurse administrators, public health nurses, and clinical nurse specialists. Out of the 88 applications reviewed for this program in fiscal year 2005, 43 new grants were awarded, and 114 were continued. In addition, 422 schools of nursing received traineeship grants, which in turn directly supported 9,000 individual student nurses.

The health system's increasing demand for primary care, increased utilization of case-management—particularly for chronic illnesses, prevention and cost-efficiency, and a shortage of physicians are driving the Nation's need for nurse practitioners, certified nurse-midwives, and other RNs with graduate education and advanced clinical skills, known as advanced practice registered nurses (APRNs). Mounting studies demonstrate the quality and cost effectiveness of APRN care. This is especially important for the 78 million aging Baby Boomers, whose demand for health care services will skyrocket in the near future. The rate of physician office visits by Medicare beneficiaries jumped 20.5 percent from 1992 to 2001, according to the Federal report Older Americans 2004: Key Indicators of Well-Being.

Workforce Diversity Program (Sec. 821).—These grants prepare disadvantaged students to become nurses. As the United States becomes ever more heterogeneous, it is imperative that the composition of our nursing workforce mirrors this shift. According to the U.S. Census Bureau, roughly 30 percent of the population was reported as a racial or ethnic minority in 2000, but by 2050 that percentage will jump to over 52 percent. This program awards grants to schools of nursing and other entities seeking to increase access to nursing education for disadvantaged students, including those racial and ethnic minorities under-represented among RNs. Scholarships or stipends, pre-entry preparation, and retention activities are provided to enable students to complete their nursing education. In fiscal year 2005, 171 applications were reviewed, from those 11 new grants were awarded and 48 previously awarded grants were continued. These program funds assisted at least 6,344 students. Workforce Diversity received $16.11 million in fiscal year 2006.

At Risk: Nursing Student Loan Program (Sec. 835).—This revolving loan fund was established in 1964 to specifically target nursing workforce shortages. The Nursing Student Loan (NSL) program provides participating undergraduate or graduate nursing students with a maximum of $13,000 in loans at 5 percent interest. Schools of nursing participating in the NSL select recipients and determine the level of assistance provided, with a preference for those with financial need. New loans are made as existing loans are repaid. This program has not received additional appropriations since 1983. However, in fiscal year 2005, the NSL provided financial assistance to 17,240 nursing students. In fiscal year 2005, Sec. 222 of the Consolidated Appropriations Act of 2005 (Public Law 108–447) included language which stated: "The unobligated balance of the Nursing Student Loan program authorized by section 835 of the Public Health Services Act is rescinded." As a result, the NSL gave back $6.1 million to the U.S. Treasury in July 2005. In previous years, those funds were redistributed among participating institutions, increasing the amount of possible loans. A similar provision, in the fiscal year 2006 appropriations law will force the NSL to return even more funds to the Treasury that instead could have assisted nursing students in completing their education.

NATIONAL INSTITUTE OF NURSING RESEARCH

One of the 27 Institutes and Centers at the National Institutes, of Health (NIH), the efforts of the National Institute of Nursing Research (NINR) improve patient care and foster advances in nursing and other health professions' practice. These practices must be must constantly updated and validated based on rigorous, peer-reviewed research. The outcomes-based findings derived from NINR research are important to the future of the health care system and its ability to deliver safe, cost-effective, and high quality care. Through grants, research training, and interdisciplinary collaborations, NINR addresses care management of patients during illness and recovery, reduction of risks for disease and disability, promotion of healthy lifestyles, enhancement of quality of life in those with chronic illness, and care for individuals at the end of life. To advance this research, AACN requests a funding level of $150 million in fiscal year 2007, an additional $12.66 million over the $137.34 million NINR received in fiscal year 2006.

NINR Addresses the Need for Translational and Clinical Research

NINR emphasizes translational research, the means by which basic findings relating to behavior, molecules, and genes are tested in the clinical setting and translated into innovative medical practices and improvements in public health. Under the framework of the Roadmap Initiative, NINR and nurse researchers are addressing the development of new interdisciplinary research teams and enhanced clinical research to move the overall NIH portfolio of social, behavioral, and medical research forward in this coordinated and cohesive effort.

NINR Addresses the Shortage of Nurse Researchers and Faculty

NINR allocates 8 percent of its budget, a high proportion when compared to other NIH institutes, to research training to help develop the pool of nurse researchers. In fiscal year 2005, NINR training dollars supported 80 individual researchers and provided 155 institutional awards, which in turn supported a number of nurse researchers at each site. Since nurse researchers often serve as faculty members for colleges of nursing, they are actively educating our next generation of RNs.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

While NIH supports biomedical research that improves health care by focusing on the cause, cure, and prevention of disease, the Agency for Healthcare Research and Quality (AHRQ) supports health systems research, collecting evidence-based information on health care outcomes. AHRQ research findings are used by patients, clinicians, health system decision makers, and public policymakers to guide health care delivery systems and patient care. The research supported by AHRQ not only improves the quality of health care services, but also helps people make more informed decisions about their health care. AACN joins the Friends of AHRQ in recommending a funding level of $440 million for fiscal year 2007, an additional $121.3 million over the fiscal year 2006 level of $318.7 million.

Health Systems Research at AHRQ Addresses Nurses' Role in Patient Safety

AHRQ research has demonstrated that inefficient work processes, overwhelming workloads, extended work hours, and poor workplace designs create obstacles to providing patients safe, cost-effective, and high quality health care. The New England Journal of Medicine published a study of over 6 million patients in May 2002, that found hospitalized patients had better outcomes when the majority of their nursing care was provided by RNs. Decreased hours of RN care, stemming from the nursing shortage, correlated with longer hospital stays, increased incidence of urinary tract infections and gastrointestinal bleeding, as well as higher rates of pneumonia, shock, and cardiac arrest. When patients received additional hours of RN care, the death rates dropped for pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, and deep venous thrombosis.

CONCLUSION

AACN acknowledges the fiscal challenges that the subcommittee and the entire Congress must work within. However, the health needs of our Nation must be addressed by a dedicated, long-term vision for educating the new nursing workforce. Today, nurses must evaluate research that promotes evidence-based practice and utilize technical innovations in providing safe, high quality patient care. Research shows that patient care suffers and mortality rates increase in facilities without sufficient numbers of RNs. Without highly educated nurses, who will care for us when we must enter into our increasingly complex health care system?

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

On behalf of the American Association of Colleges of Osteopathic Medicine (AACOM) which represents the administrations, faculties and students of all twenty colleges of osteopathic medicine in the United States, I am pleased to present our views on the fiscal year 2007 appropriations for health professions education programs under Title VII of the Public Health Service Act.

First, we must express our profound concern at the devastating cuts proposed by the administration for Title VII programs in its fiscal year 2007 budget. The Bureau of Health Professions received $342 million in cuts in the President's fiscal year 2007 proposal which is fully 46 prepared of its entire budget. While we support the $181 million increase in the President's budget for Community Health Centers, the large funding decreases to the Title VII programs raises the question of whether there will be a sufficient number of health care providers to staff these clinics. The fiscal year 2007 cuts are in addition to the 12 programs that were eliminated in the fiscal year 2006 appropriations bills, as well as other programs that received significant decreases in both years. Congress must not allow these draconian slashes to cripple the programs that assist health professions schools in training the workforce needed to care for our citizens in the 21st century.

A study that recently appeared in the Journal of the American Medical Association recommends increased Titles VII and VIII support to alleviate provider shortages at Community Health Centers [Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion, Roger A. Rosenblatt, C. Holly. A. Andrilla, Thomas Curtin; L. Gary Hart, Journal of the American Medical Association, JAMA 2006;295:1042–1049]. The study found that Titles VII and VIII programs help ameliorate these shortages and maldistribution by training providers who are more likely to practice in rural and underserved communities.

Health professions education programs under Title VII and nursing education programs under Title VIII are essential components of America's health care safety net. An adequate diverse, well-distributed and culturally competent health workforce is indispensable to our national readiness efforts. Colleges of osteopathic medicine have a long tradition of training primary care physicians who practice in rural and urban underserved areas.

The health professions education programs under Title VII and the nursing education programs under Title VIII of the Public Health Service Act have been valuable in our efforts to continue to ensure this commitment. In Public Law 105–392, the Health Professions Education Partnership Act of 1998, forty-four different Federal health professions training programs were consolidated into seven clusters. These clusters provide support for training of primary care and dental providers; the establishment and operation of interdisciplinary community-based training activities; health professions workforce analysis; public health workforce development; nursing education; and student financial assistance. These programs are designed to meet the health care delivery needs of over 2,800 Health Professions Shortage Areas in the country. Many rural and disadvantaged populations depend on the health professionals trained by these programs at their only source of health care. For example, without the practicing family physicians who are currently in place, an additional 1,332 of the United States' 1,082 urban and rural counties would qualify for designation as primary care Health Professions Shortage Areas.

Title VII programs have had a significant impact in reducing the Nation's Health Professions Shortage Areas. Indeed, a 1999 study estimated that if funding for Title VII programs were doubled the effect would be to eliminate the Nation's Health Professions Shortage Areas in as little as 6 years. [Politzer, RM, Hardwick, KC, Cultice, JM, Bazell, C. "Eliminating Primary Care Health Professions Shortage Areas: The Impact of Title VII Generalist Physician Education," The Journal of Rural Health, 1999: 15(1): 11–19].

A study by the Robert Graham Center showed that receipt of Title VII family medicine grants by medical schools produced more family physicians and more primary care doctors serving rural areas and health professions shortage areas. Over 69 percent of Title VII funded internal medicine graduates practice primary care after graduation. This rate is nearly twice that of programs not receiving Title VII funding.

Among the programs within these clusters that have been especially important to enhancing osteopathic medical schools' ability to train the highest quality physicians are: General Internal Medicine Residencies; General Pediatric Residencies; Family Medicine Training; Preventive Medicine Residencies; Area Health Education Centers (AHECs); Health Education and Training Centers (HETCs); Health Careers Opportunities Programs (HCOP); and Centers of Excellence (COE) programs.

In addition, three Title VII programs offer interdisciplinary training for all health professions. The Geriatric Education Centers (GEC) program provides grants to support collaborative arrangements involving several health professions schools and health facilities that provide training in the diagnosis, treatment and prevention of disease and other health concerns of the elderly. The Geriatric Training program for physicians, dentists, and mental health professionals (GT) provides for these professionals who plan to become faculty members. The Geriatric Academic Career Awards (GACA) support the career development of geriatricians in junior faculty positions who are committed to an academic career of teaching clinical geriatrics in medical schools.

Accordingly, Mr. Chairman and Members of the subcommittee, AACOM recommends that the fiscal year 2007 funding levels for Titles VII Health Professions Education and VIII Nursing Education be $299,552,000. You will note that this is the same level as the Congress approved for fiscal year 2005.

AACOM also strongly urges continuation of funding for the Council on Graduate Medical Education (COGME). Since its inception, COGME's diverse membership has given the health policy community an opportunity to discuss national workforce issues. The fifteen formal reports and multiple ancillary materials provided by COGME have offered important findings and observations in the rapidly changing health care environment and have argued for a system of graduate medical education that develops a physician workforce to meet the healthcare needs of the American people.

Some of the more significant recommendations include:

—Community-based education with an emphasis on primary care;

—Continued progress toward a more representative participation of minorities in medicine;

—The development and maintenance of a workforce planning infrastructure to improve the understanding of supply, need and demand forces;

—The development of Federal-State partnerships to further workforce planning; and

—Encouragement and support for medical education and health care delivery programs that increase the flow of physicians to rural areas, with an emphasis on the smaller, more remote communities.

In summary, Mr. Chairman and Members of the subcommittee, health profession education programs under Title VII are an essential part of the healthcare safety net for all Americans. We respectfully urge you to restore funding for these programs at the fiscal year 2005 level. Please contact me or Michael J. Dyer, AACOM's Vice President for Government Relations at (301) 968–4152 if you have any questions.

PREPARED STATEMENT OF THE AMERICAN NURSES ASSOCIATION

The American Nurses Association (ANA) appreciates this opportunity to comment on fiscal year 2007 appropriations for nursing education, workforce development, and research programs. Founded in 1896, ANA is the only full-service national association representing registered nurses (RNs). Through our 54 constituent member associations, ANA represents RNs across the Nation in all practice settings.

The ANA gratefully acknowledges this subcommittee's history of support for nursing education and research. We appreciate your continued recognition of the important role nurses play in the delivery of quality health care services. This testimony will give you an update on the status of the nursing shortage, its impact on the Nation, and the outlook for the future.

THE NURSING SHORTAGE TODAY

The nursing shortage is far from solved. Here are a few quick facts:

—According to American Hospital Association's 2005 Workforce Survey, 109,000 nurses are needed immediately to fill vacancies at our Nation's hospitals. In addition, 40 percent of the hospitals surveyed reported that RN recruitment was more difficult in 2004 than in 2003.

—The Bureau of Labor Statistics reported in February of this year that registered nursing will have remarkable job growth in the time period spanning 2004–2014. During this time decade, the health care system will require more than 1.2 million new nurses.

—The report issued by the Division of Nursing at the Health Resources and Services Administration in 2002 projects that, absent aggressive intervention, the supply of nurses in America will fall 29 percent below requirements by the year 2020.

This growing nursing shortage is having a detrimental impact on the entire health care system. Numerous studies have shown that nursing shortages contribute to medical errors, poor patient outcomes, and increased mortality rates. A study published in the January/February 2006 issue of Health Affairs showed that hospitals could avoid 6,700 deaths per year by increasing the amount of RN care provided to their patients. This study, "Nurse Staffing in Hospitals: Is There a Business Case for Quality?" by Jack Needleman, Peter Buerhaus, Maureen Stewart, Katya Zelevinsky and Soeren Mattke, also revealed that hospitals could avoid 4 million hours worth of inpatient care by avoiding the complications associated with a shortage of RN care.

This study built upon research published in the New England Journal of Medicine in May 2002. The 2002 research was based on a review of more than 6 million patients. It found that increased hours of RN care were associated with fewer "failure-to-rescue" deaths in hospitalized patients resulting from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis and deep venous thrombosis.

Research published in the October 23, 2002 Journal of the American Medical Association also demonstrated that more nurses at the bedside could save thousands of patient lives each year. In reviewing more than 232,000 surgical patients at 168 hospitals, researchers from the University of Pennsylvania concluded that a patient's overall risk of death rose roughly 7 percent for each additional patient above four added to a nurse's workload.

A Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) study published in 2002 shows that the shortage of nurses contributes to nearly a quarter of all unexpected incidents that kill or injure hospitalized patients.

THE IMPACT ON PREPAREDNESS AND MILITARY HEALTH CARE

This growing nursing shortage has effects well beyond traditional domestic health care. RNs are integral to everything from pandemic flu management, to terrorism preparedness, to veterans' health delivery, to disaster response. In the event of a terrorist attack or pandemic flu outbreak, nurses will be needed to evaluate patients, administer vaccines and medications, perform disease surveillance, and to train non-licensed staff. The GAO has repeatedly reported that the nursing shortage is complicating efforts at the State and local level to implement pandemic flu and bioterrorism preparedness efforts (see: GAO: 03–654T, 03–769T, 04–458T, 05–760T, 05–863T). For instance, in May 2003, the GAO testified, "Five of the [seven] States we visited reported shortages of hospital medical staff, including nurses and physicians, necessary to increase response capacity in an emergency." (GAO–03–769T).

The nursing shortage is also stressing military health care delivery. The Army, Navy, and Air Force are offering new lucrative RN recruitment packages that include large sign-on bonuses, generous scholarships, and loan forgiveness packages. Yet, neither the Army nor the Air Force has met their active service nurse recruitment goals since the 1990s. On May 10, 2005, Army leaders warned the Senate Appropriations Committee that they were experiencing a 30 percent shortage of certified registered nurse anesthetists. In 2004, the Navy Nurse Corps recruitment fell 32 percent below target. Because the military holds the vast majority of its health care assets in the reserves, the reserve activation has been particularly hard on nursing. This ongoing nurse shortage is creating real concerns about the ability to deliver needed health care to today's military.

NURSING WORKFORCE DEVELOPMENT PROGRAMS

Federal support for the Nursing Workforce Development Programs contained in Title VIII of the Public Health Service Act is unduplicated and essential. The 107th Congress recognized the detrimental impact of the developing nursing shortage and passed the Nurse Reinvestment Act (Public Law 107–205). This law improved the programs of Title VIII to meet the unique characteristics of today's shortage. This achievement holds the promise of recruiting new nurses into the profession, promoting career advancement within nursing and improving patient care delivery. This promise will not be met, however, without a significant investment.

In fiscal year 2005, this subcommittee allocated $151 million in funding for Title VIII which supported 52,795 individual grants. In fiscal year 2006, you allocated $150 million for Title VIII. While ANA applauds your ongoing recognition for these nursing workforce development programs, we also recognize that these funding levels fail to meet the challenges of the growing nursing shortage. For instance, in fiscal year 2005, 4,465 RNs applied for the Nurse Education Loan Repayment Program (described fully below). Due to lack of funding, a mere 803 (18 percent) were approved.

ANA strongly urges you to increase funding for Title VIII programs by at least $25 million to a total of $175 million in fiscal year 2007. This funding amount has been supported by a bipartisan group of 54 Senators in a Dear Colleague sent to this subcommittee. The nursing shortage and its impact on the health care of the Nation demand this continued investment.

In 1974, this subcommittee invested $153.6 million Title VIII. Inflated to today's dollars, this appropriation would equal $622.5 million, more than four times the current appropriation. Certainly, today's shortage is more dire and systemic than that of the 1970's; it deserves an equivalent response.

Title VIII includes the following program areas:

Nursing Education Loan Repayment Program & Scholarships.—This line item is comprised of the Nurse Education Loan Repayment Program (NELRP) and the Nursing Scholarship Program (NSP), the Secretary of HHS has the authority to allocate funds between the two areas. In fiscal year 2006, the Nurse Education Loan Repayment Program and Scholarships received $31 million.

The NELRP repays up to 85 percent of a RN's student loans in return for full-time practice in a facility with a critical nursing shortage. The NELRP nurse is required to work for at least 2 years in a designated facility during which time the NELRP repays 60 percent of the RN's student loan balance. If the nurse applies and is accepted for a third year, an additional 25 percent of the loan is repaid.

The NELRP boasts a proven track record of delivering nurses to facilities hardest hit by the nursing shortage. HRSA has given NELRP funding preference to RNs who work in disproportionate share hospitals, skilled nursing facilities, federally-designated health centers, and departments of public health. However, lack of funding has hindered the full implementation of this program. As stated above, in fiscal year 2005, 82 percent of the nurses willing to immediately begin practicing in facilities hardest hit by the shortage were turned away from this program due to lack of funding.

The NSP offers funds to nursing students who, upon graduation, agree to work for at least 2 years in a health care facility with a critical shortage of nurses. Preference is given to students with the greatest financial need. Like the loan repayment program, the NSP has been stunted by a lack of funding. In fiscal year 2005, HRSA received 6,563 applications for the nursing scholarship. Due to lack of funding, a mere 217 scholarships were awarded. Therefore, 97 percent of nursing students willing to work in facilities with a critical shortage were denied access to this program.

Nurse Faculty Loan Program.—This program establishes a loan repayment fund within schools of nursing to increase the number of qualified nurse faculty. Nurses may use these funds to pursue a master's or doctoral degree. They must agree to teach at a school of nursing in exchange for cancellation of up to 85 percent of their educational loans, plus interest, over a 4-year period. Loans can cover the costs of tuition, fees, books, laboratory expenses, and other reasonable education expenses. In fiscal year 2006, this program received $4.8 million.

This program is vital given the critical shortage of nursing faculty. America's schools of nursing cannot increase their capacity without an influx of new teaching staff. Last year, schools of nursing were forced to turn away tens of thousands of qualified applicants due largely to the lack of faculty. In fiscal year 2005, HRSA awarded 66 nurse faculty loan repayments.

Nurse Education, Practice, and Retention Grants.—This section is comprised of many programs designed to support entry-level nursing education and to enhance nursing practice. In fiscal year 2005, this line item supported 10,490 nursing students. All together, the Nurse Education, Practice, and Retention Grants received $37.3 million in fiscal year 2006.

The education grants are designed to expand enrollments in baccalaureate nursing programs; develop internship and residency programs to enhance mentoring and specialty training, and; provide new technologies in education including distance learning.

Practice grants currently support 18 Nurse Managed Clinics that provide primary health care in medically underserved communities; provide nursing students the skills necessary to practice in existing and emerging health systems, and; develop cultural competencies.

Retention grant areas include career ladders and improved patient care delivery systems. The career ladders program supports education programs that assist individuals in obtaining the educational foundation required to enter the profession, and to promote career advancement within nursing. Enhancing patient care delivery system grants are designed to improve the nursing work environment. These grants help facilities to enhance collaboration and communication among nurses and other health care professionals, and to promote nurse involvement in the organizational

and clinical decision-making processes of a health care facility. These best practices for nurse administration have been identified by the American Nurse Credentialing Center's Magnet Recognition Program ®. These practices have been shown to double nurse retention rates, increase nurse satisfaction, and improve patient care.

Nursing Workforce Diversity.—This program provides funds to enhance diversity in nursing education and practice. It supports projects to increase nursing education opportunities for individuals from disadvantaged backgrounds—including racial and ethnic minorities, as well as individuals who are economically disadvantaged. In fiscal year 2006, these programs received $16 million.

Racial and ethnic minorities currently comprise more than 25 percent of the Nation's population and will comprise nearly 40 percent by the year 2020. However, only 10.6 percent of the RNs in the United States are self-identified as one or more of the racial and ethnic minority groups. Increasing cultural and ethnic diversity in nursing helps to address the prevention, treatment, and rehabilitation needs of an increasingly diverse population. For fiscal year 2005, HRSA received 191 submissions for nursing workforce diversity grants. HRSA was able to fund 97 (50 percent of applications).

Advanced Nurse Education.—Advanced practice registered nurses (APRNs) are nurses who have attained advanced expertise in the clinical management of health conditions. Typically, an APRN holds a master's degree with advanced didactic and clinical preparation beyond that of the RN. Most have practice experience as RNs prior to entering graduate school. Practice areas include, but are not limited to: anesthesiology, family medicine, gerontology, pediatrics, psychiatry, midwifery, neonatology, and women's & adult health. Title VIII grants have supported the development of virtually all initial State and regional outreach models using distance learning methodologies to provide advanced study opportunities for nurses in rural and remote areas. In fiscal year 2006, these programs received $57 million.

These grants also provide traineeships for masters and doctoral students. Title VIII funds more than 60 percent of U.S. nurse practitioner education programs and assists 83 percent of nurse midwifery programs. Over 45 percent of the nurse anesthesia graduates supported by this program go on to practice in medically underserved communities. Many provide care to minority or disadvantaged patients. In fiscal year 2005, HRSA funded 81 advanced education nursing grants (89 percent of applications), 347 advanced education nursing traineeships (every application), and 75 nurse anesthetist traineeships (every application).

Comprehensive Geriatric Education Grants.—This authority awards grants to train and educate nurses in providing health care to the elderly. Funds are used to train individuals who provide direct care for the elderly, to develop and disseminate geriatric nursing curriculum, to train faculty members in geriatrics, and to provide continuing education to nurses who provide geriatric care. In fiscal year 2006, these grants received $3.4 million.

The growing number of elderly Americans and the impending health care needs of the baby boom generation make this program critically important. In fiscal year 2005, HRSA received 43 applications for comprehensive geriatric education grants. HRSA continued 17 previously awarded grants and awarded 11 new ones (65 percent of applications).

NATIONAL INSTITUTE OF NURSING RESEARCH (NINR)

ANA also urges the subcommittee to increase funding for the NINR, one of the institutes at the National Institutes of Health (NIH). This research is integral to improving the effectiveness of nursing care. Advances in nursing care arising from behavioral and biomedical research have shown excellent progress in reducing health care costs. Research programs supported by NINR address a number of critical public health and patient care questions. The research is driven by real and immediate problems currently facing patients and their families.

Recent studies have illuminated the impact of placing a patient in long term care on the patient's family caregiver, the impact of maternal obesity prior to pregnancy on childhood weight problems, the difference in heart attack symptoms in women versus men, the most effective means to prevent infectious diseases in inner city households, and the incidence and risk factors for uterine rupture in pregnancies following cesarean section. NINR is leading the NIH research on end-of-life and palliative care. NINR is also the lowest funded institute at NIH. In fiscal year 2006, NINR received $137.3 million. ANA recommends $150 million in fiscal year 2007 NINR funding.

CONCLUSION

While ANA appreciates the continued support of this subcommittee, we are concerned that Title VIII funding levels have not been sufficient to address the growing nursing shortage. The nursing shortage will continue to worsen if significant investments are not made. Recent efforts have shown that aggressive and innovative recruitment efforts can help avert the impending nursing shortage—if they are adequately funded.

ANA asks you to meet today's shortage with a relatively modest investment of $175 million in Title VIII programs. Additionally, an investment of $150 million in the NINR will help assure that these nurses are equipped with the information needed to provide the best care possible.

PREPARED STATEMENT OF AMERICANS FOR NURSING SHORTAGE RELIEF

The undersigned organizations of the ANSR (Americans for Nursing Shortage Relief) Alliance greatly appreciate the opportunity to submit written testimony regarding fiscal year 2007 appropriations for Title VIII—Nursing Workforce Development Programs. The ANSR Alliance is comprised of fifty-one national nursing organizations that united in 2001 to identify and promote creative strategies for addressing the nursing and nurse faculty shortages, including passage of the Nurse Reinvestment Act of 2002—an important first step in increasing the number of qualified nurses in America.

ANSR stands ready to work with policymakers to advance programs and policies that will sustain and strengthen our Nation's nursing workforce. To ensure that our Nation has a sufficient and adequately prepared nursing workforce to provide quality care to every American well into the 21st century, ANSR advocates for the following:

—At least $175 million in funding for Nursing Workforce Development Programs under Title VIII of the Public Health Service Act at the Health Resources and Services Administration (HRSA) in fiscal year 2007.

THE NURSING SHORTAGE

Nurses play a critical role in this Nation's health care system. With an estimated 2.9 million licensed registered and advanced practice registered nurses (RNs and APRNs), nurses represent the largest occupational group of health care workers and provide patient care in virtually all locations in which health care is delivered. This coupled by their scope of practice areas make the nursing shortage an even more interesting challenge. Some facts to consider:

—The nursing workforce is aging. In 1980, 26 percent of RNs were under the age of 30. Today, approximately 8 percent of RNs are under the age of 30 with the average nurse 46.8 years of age;

—Approximately half of the RN workforce is expected to reach retirement age within the next 10 to 15 years. The average age of new RN graduates is almost 30 years.

—The Bureau of Labor Statistics report (December, 2005) projected that registered nursing would create the second largest number of new jobs among all occupations within 9 years. In addition, employment of registered nurses is expected to grow much faster than average for all occupations through 2014. It is anticipated that approximately 703,000 additional jobs, for a total of 3,096,000, will be available for RNs by this date.

—The national nursing shortage also is affecting our Nation's 7.6 million veterans who receive care through the 1,300 Veterans Administration (VA) health care facilities;

—Nearly 1,800 faculty members leave their positions every year due to factors of retirement or higher wages earned as a staff nurse. Fewer than 400 faculty candidates receive their doctoral degrees each year; and,

—The number of full-time nurse faculty required to "fill the nursing gap" is approximately 40,000. Currently, the National League for Nursing estimates that there fewer than 10,000 full-time faculty members in the system.

THE NURSING SUPPLY IMPACTS AMERICA'S EMERGENCY PREPAREDNESS

Nurses play a critical role as front-line, first-responders. When word of the devastation caused by Hurricanes Katrina and Rita spread, nurses across the country immediately volunteered in American Red Cross shelters, medical clinics, and hospitals throughout that area. Nurse midwives delivered babies in airplane hangars, and nurses trained in geriatric care assisted in caring for those evacuated from the

comforts of their homes, assisted living facilities or nursing homes. Nurse practitioners diligently staffed temporary and permanent health care clinics to provide needed primary care to hurricane victims. In addition, many nurses realized their role in the comfort and support they offered as they listened to survivors recount their stories of pain and tragedy.

These stories seem particularly relevant in demonstrating the contributions that nurses provide during tragedies, and should illustrate the need to ensure an adequate supply of all types of nurses in all parts of the country. Unless steps are taken now, the Nation's ability to respond to disasters will be further hindered by the growing nursing shortage. An investment in the nursing workforce is a step in the right direction to bolster our public health infrastructure and increase our Nation's health care readiness and emergency response capabilities.

THE DESPERATE NEED FOR NURSE FACULTY

After years of declining interest, the nursing profession is seeing the opposite occur. Many Americans have come to find nursing an attractive career because of job security, salary levels, and the opportunity to help others. However, the common theme among prospective nursing students is that due to a lack of a sufficient number of faculty they can face waiting periods of up to 3 years before matriculating. When all nursing programs are considered, the number of qualified applications turned away during the 2004–2005 academic year was estimated to be more than 147,000 by the National League for Nursing. Without sufficient support for current nurse faculty and adequate incentives to encourage more nurses to become faculty, nursing schools will fail to have the teaching infrastructure necessary to educate and train the next generation of nurses that the Nation so desperately needs.

THE FUNDING REALITY

Enacted in 2002, the Nurse Reinvestment Act included new and expanded initiatives, including loan forgiveness, scholarships, career ladder opportunities, and public service announcements to advance nursing as a career. Despite the enactment of this critical measure, HRSA fails to have the resources necessary to meet the current and growing demands for our Nation's nursing workforce. For example, in fiscal year 2003, HRSA received 8,321 applications for the Nurse Education Loan Repayment Program but only had the funds to award 7 percent (602) of all applications. Also in fiscal year 2003, HRSA received 4,512 applications for the Nursing Scholarship Program but only had funding to support a mere 2 percent (94) of all applications.

The ANSR Alliance strongly urges this subcommittee to provide a minimum of $17,505 million in fiscal year 2007 to fund Title VIII—Nursing Workforce Development Programs. This level of investment will help leverage the HRSA resources to fund a higher rate of Nurse Education Loan Repayment and Nursing Scholarship applications, as well as implement other essential endeavors to sustain and boost our Nation's nursing workforce.

SUMMARY

Programmatic area	Final fiscal year 2006	President's budget fiscal year 2007	ANSR's request
Title VIII: Nurse Workforce Development Programs at HRSA ..	$149,000,000	$150,000,000	$175,000,000

ANSR ALLIANCE ORGANIZATIONS

Academy of Medical-Surgical Nurses; American Academy of Ambulatory Care Nursing; American Academy of Nurse Practitioners; American Association of Critical-Care Nurses; American Association of Nurse Anesthetists; American Association of Occupational Health Nurses, Inc.; American College of Nurse-Midwives; American Organization of Nurse Executives; American Society for Pain Management Nursing; American Society of PeriAnesthesia Nurses; American Society of Plastic Surgical Nurses; Association of periOperative Registered Nurses; Association of Rehabilitation Nurses; Association of State and Territorial Directors of Nursing; Association of Women's Health, Obstetric and Neonatal Nurses; Dermatology Nurses' Association; Developmental Disabilities Nurses Association; Emergency Nurses Association; Infusion Nurses Society; National Association of Clinical Nurse Specialists; National Association of Nurse Massage Therapists; National Association of Orthopaedic Nurses; National Association of Pediatric Nurse Practitioners; National Association of School Nurses; National Black Nurses Association; National Conference of Gerontological Nurse Practitioners; National Council of State Boards of Nursing; National

League for Nursing; National Student Nurses' Association; National Nursing Centers Consortium; National Organization of Nurse Practitioner Faculties; Nurses Organization of Veterans Affairs; Oncology Nursing Society; Society for Urologic Nurses and Associates; Society of Trauma Nurses; and Wound Ostomy Continence Nurses Society.

PREPARED STATEMENT OF THE AMERICAN PUBLIC POWER ASSOCIATION

The American Public Power Association (APPA) is the national service organization representing the interests of over 2,000 municipal and other State and locally owned utilities throughout the United States (all but Hawaii). Collectively, public power utilities deliver electricity to one of every seven electricity consumers (approximately 43 million people), serving some of the Nation's largest cities. However, the vast majority of APPA's members serve communities with populations of 10,000 people or less.

We appreciate the opportunity to submit this statement supporting funding for the Low-Income Home Energy Production Assistance Program (LIHEAP).

APPA has consistently supported an increase in the authorization level for LIHEAP and supports the full authorization level of $5.1 billion for fiscal year 2007 as enacted in the Energy Policy Act of 2005.

APPA is proud of the commitment that its members have made to their low-income customers. Many public power systems have low-income energy assistance programs based on community resources and needs. Our members realize the importance of having in place a well-designed low-income customer assistance program combined with energy efficiency and weatherization programs in order to help consumers minimize their energy bills and lower their requirements for assistance. While highly successful, these local initiatives must be coupled with a strong LIHEAP program to meet the growing needs of low-income customers. In the last several years, volatile home-heating oil and natural gas prices, severe winters, high utility bills as a result of dysfunctional wholesale electricity markets and the effects of the economic downturn have all contributed to an increased reliance on LIHEAP funds.

Also when considering LIHEAP appropriations this year, we encourage the subcommittee to provide advanced funding for the program so that shortfalls do not occur in the winter months during the transition from one fiscal year to another. LIHEAP is one of the outstanding examples of a State-operated program with minimal requirements imposed by the Federal Government. Advanced funding for LIHEAP is critical to enabling States to optimally administer the program.

Thank you again for this opportunity to relay our support for increased LIHEAP funding for fiscal year 2007. We look forward to a favorable outcome.

PREPARED STATEMENT OF THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS

The Association of Maternal and Child Health Programs (AMCHP) is a national, non-profit organization representing leaders of State public health programs for maternal and child health, including children with special health care needs, in all 50 States, the District of Columbia, and eight additional jurisdictions. Our members administer Title V Maternal and Child Health Services Block Grant funds to improve the health of mothers and children. We strongly urge you to restore funding for the MCH Block Grant to the fiscal year 2005 level of $724 million.

First authorized in 1935, the MCH Block Grant provides for a wide range of health services and fosters prevention of disease and disabling conditions for over 32 million women and children across the country. Funds from the MCH Block Grant enable States to provide women with prenatal and postnatal care, screen newborns for genetic and hereditary conditions; support childhood immunizations; reduce infant mortality and developmentally handicapping conditions; and prevent childhood accidents and injuries. Block grant funding enables State agencies to tailor vital programs for women, children and families to the needs of each community, while ensuring that the programs meet national goals.

Since the program's inception, it has evolved into a powerful Federal-State partnership. Each year, $600 million Federal are matched by over $5 billion in State funds for maternal and child health programs. These funds have enabled States to reach more than 80 percent of infants, 50 percent of pregnant women and 20 percent of children in the United States. Since 2000, the number of women and children served has increased by almost 5 million, an increase of 18 percent.

In fiscal year 2006, $693 million was appropriated for the MCH Block Grant, $31 million below the fiscal year 2005 comparable appropriation. This loss of funds, as the number of women and children needing services continues to increase, will impact the ability of States to address areas of critical need. While President Bush recommended level funding for the MCH program in his budget request, he also recommended that Federal support for the Traumatic Brain Injury program, Universal Newborn Hearing Screening, Emergency Medical Services for Children and the Sickle Cell Anemia Demonstration Project be eliminated. If this recommendation were enacted without a commensurate increase in the block grant, States would be forced to shift MCH Block Grant funds away from other pressing health priorities to meet those addressed by these programs. We recommend that funding for these four valuable programs be restored, in addition to the restoration of the MCH Block Grant funding to the fiscal year 2005 level.

The flexibility of the block grant has allowed States to respond to emerging health issues that affect women and children, such as the rising infant mortality rates, particularly among minority populations, and the availability of newborn screening for a newly expanded range of diseases and disorders. Reducing the infant mortality rate is a goal of the MCH Block Grant program, which will be difficult to achieve if funding continues to erode. State maternal and child health programs coordinate newborn screening and follow-up services, activities to ensure that every infant born in this country receives screening tests that detect disorders that could result in death or permanent disabilities. The money spent on these screening programs saves lives, and preserves State and Federal Government dollars that would otherwise be spent on expensive, lifelong treatment and rehabilitative services for infants whose genetic disorders go undetected. Level funding of the MCH Block Grant will not allow States to meet the increasing demand for newborn screening services.

Last year's budget cut has already had a real impact on State programs, threatening the quality and quantity of care these programs provide. The MCH Block Grant can not continue to do more with less. Consider the following descriptions of the impact these cuts are having at the State level:

—In Iowa, the impact of the MCH Block Grant cut means that the State will not have the resources to address emerging public health issues, such as planning for a potential bird flu pandemic. It will, instead, be necessary to direct Title V resources toward continuing existing programs. Infant mental health, smoking cessation during pregnancy and obesity prevention programs will all be short-changed as a consequence.

—Funding has been pulled from a large Healthy Communities Access Program project in Washoe County, Nevada because of this year's cuts just as it was making great inroads in systems development for access to care for low-income families in that county. Nevada has a community-based prenatal program that reached 600 participants in its first year. Demand for services has tripled this year. Further cuts to the MCH Block Grant would necessitate cutting this program, so fewer pregnant women would be served. The MCH program has had to drop all its contracts with community coalitions to promote access to care, which has hampered the success of these activities.

—Alabama lost $409,339 in block grant funding in fiscal year 2006. The Alabama MCH program has reduced staffing by attrition at both the central office and county office levels. Nursing and nursing assistants, administrative support, and epidemiology services and medical equipment and supplies have been affected.

—In Washington State, reductions in the MCH Block grant, impact women and children by minimizing or eliminating local community activities. Many activities will either be eliminated or drastically scaled back, including early childhood programs, adolescent health care, mental health services, the Healthy Youth Survey, newborn hearing screening, and services for children with special health care needs. Multiple Federal cuts mean than many of the MCH partners will also be reducing efforts. With this reduction, Washington State will be moving back in time, not even maintaining the status quo.

—In Michigan, cut backs in medical care and treatment for children with special health care needs will be necessary as a result of the $656,000 reduction in its allocation.

The dramatic effects are not unique to Iowa, Nevada, Alabama, Washington State or Michigan, but affect all States and jurisdictions.

AMCHP recognizes the fiscal restraints facing this subcommittee. Nevertheless, we can not stress enough what a dire situation MCH Block Grant cuts are creating, especially given the cuts in the Medicaid program and the fact that other safety net programs also face reductions. Title V programs play a valuable, complementary role to the SCHIP and Medicaid programs. As more women and children are forced

out of the Medicaid program, they will turn to MCH programs to ensure that their health care needs are met. With increased demand for MCH Block Grant services, States will be forced to limit already stretched services to vulnerable populations.

Our children are the future. Their needs should not be short-changed by budget limitations, but addressed effectively with adequate funding. The MCH Block Grant has a proven track record of effectiveness and supports health services for over 32 million Americans. We strongly urge you to restore funding for the MCH Block Grant to the fiscal year 2005 level of $724 million.

PREPARED STATEMENT OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION COALITION

The CDC Coalition is a nonpartisan coalition of more than 100 groups committed to strengthening our Nation's prevention programs. Our mission is to ensure that health promotion and disease prevention are given top priority in Federal funding, to support a funding level for the Centers for Disease Control and Prevention (CDC) that enables it to carry out its prevention mission, and to assure an adequate translation of new research into effective State and local programs. Coalition member groups represent millions of public health workers, researchers, educators, and citizens served by CDC programs. We are grateful to be able to present our views to the subcommittee.

The CDC Coalition continues to believe that Congress should support CDC as an agency—not just the individual programs that it funds. In the best judgment of the CDC Coalition—given the challenges and burdens of chronic disease, a potential influenza pandemic, terrorism, disaster preparedness, new and re-emerging infectious diseases and our many unmet public health needs and missed prevention opportunities—we believe the agency will require funding of at least $8.5 billion, plus sufficient funding to prepare the Nation against a potential influenza pandemic. This request reflects the support CDC will need to fulfill its core missions for fiscal year 2007, as well as funding for the Agency for Toxic Substances and Disease Registry and the Vaccines for Children program.

The CDC Coalition appreciates the subcommittee's work over the years, including your recognition of the need to fund chronic disease prevention, infectious disease prevention and treatment, and environmental health programs at CDC. By translating research findings into effective intervention efforts, CDC has been a key source of funding for many of our State and local programs that aim to improve the health of communities. Perhaps more importantly, Federal funding through CDC provides the foundation for our State and local public health departments, supporting a trained workforce, laboratory capacity and public health education communications systems.

CDC also serves as the command center for our Nation's public health defense system against emerging and reemerging infectious diseases. With the potential onset of a worldwide influenza pandemic, in addition to the many other natural and man-made threats that exist in the modern world, the CDC has become the Nation's—and the world's—expert resource and response center, coordinating communications and action and serving as the laboratory reference center. States and communities rely on CDC for accurate information and direction in a crisis or outbreak.

Unfortunately, Congress cut overall CDC funding in fiscal year 2006 for the first time in 25 years. And in fiscal year 2007, the President has proposed cutting CDC funding even more—more than 2 percent overall, and more than 4.5 percent to CDC's core programs. We are moving in the wrong direction, especially in these challenging times when public health is being asked to do more, not less. In light of the current workload placed on the public health service—in addition to the threat of emerging diseases such as the avian flu—it simply does not make any sense to cut the budget for CDC at a time when the threats to public health are so great. Funding public health outbreak by outbreak is not an effective way to ensure either preparedness or accountability. Until we are committed to a strong public health system, every crisis will force trade offs.

CDC serves as the lead agency for bioterrorism preparedness and must receive sustained support for its preparedness programs in order for our Nation to meet future challenges. In the best judgment of CDC Coalition members, given the challenges of terrorism and disaster preparedness, and our many unmet public health needs and missed prevention opportunities, we support the proposed increase for anti-terrorism activities at CDC, including the increases for the Strategic National Stockpile and the new Botulinum Toxin Research funding. However, we strongly caution that the President's proposed level-funding of the State and local capacity grants continues to reflect a $95 million cut from fiscal year 2005 levels. We encour-

age the subcommittee to restore these cuts to ensure that our States and local communities can be prepared in the event of an act of terrorism.

Heart disease remains the Nation's number one killer. In 2003, 684,462 people died of heart disease (51 percent of them women), accounting for 28 percent of all U.S. deaths. Stroke is the third leading cause of death after heart disease and cancer, and is a leading cause of serious, long-term disability. In 2003, stroke killed 157,800 people (61percent of them women), accounting for about 1 of every 15 deaths. In 1998, the U.S. Congress provided funding for CDC to initiate a national, State-based heart disease and stroke prevention program with funding for eight States. Currently, 32 States and the District of Columbia are funded, 19 as capacity building programs and 14 as basic implementation programs. The CDC Coalition recommends $55 million for the Heart Disease and Stroke Prevention Program.

The CDC funds proven programs addressing cancer prevention, early detection, and care. Cancer is the second most common cause of death in the United States. In 2006, about 1.4 million new cases of cancer will be diagnosed, and about 564,830 Americans—more than 1,500 people a day—are expected to die of the disease. The financial cost of cancer is also significant. According to the National Institutes of Health, in 2005, the overall cost for cancer in the United States was nearly $210 billion: $74 billion for direct medical costs, $17.5 billion for lost worker productivity due to illness, and $118.4 billion for lost worker productivity due to premature death.

Among the ways the CDC is fighting cancer, it funds the National Breast and Cervical Cancer Early Detection Program that helps low-income, uninsured and medically underserved women gain access to lifesaving breast and cervical cancer screenings and provides a gateway to treatment upon diagnosis. CDC also funds grants to States to develop Comprehensive Cancer Control (CCC) plans, bringing together a broad partnership of public and private stakeholders to jointly set priorities and implement specific cancer prevention and control activities customized to address each State's particular needs. CDC also funds programs to raise awareness about colorectal, prostate, lung, ovarian and skin cancers, and the National Program of Cancer Registries, a critical registry for tracking cancer trends in all 50 States. The CDC coalition recommends $427.5 million for the Cancer Prevention and Control activities of the CDC.

Although more than 18 million Americans have diabetes, 5.2 million cases are undiagnosed. From 1980—2002, the number of people with diabetes in the United States more than doubled, from 5.8 million to 13.3 million. Each year, 12,000—24,000 people with diabetes become blind, more than 42,800 develop kidney failure, and about 82,000 have leg, foot, or toe amputations. Preventive care such as routine eye and foot examinations, self-monitoring of blood glucose, and glycemic control could reduce these numbers. Without additional funds, most States will not be able to create programs based on these new data. States also will continue to need CDC funding for diabetes control programs that seek to reduce the complications associated with diabetes.

Over the last 25 years, obesity rates have doubled among adults and children, and tripled in teens. Obesity, diet and inactivity are cross-cutting risk factors that contribute significantly to heart disease, cancer, stroke and diabetes. The CDC funds programs to encourage the consumption of fruits and vegetables, to get sufficient exercise, and to develop other habits of healthy nutrition and activity. The CDC Coalition recommends $70 million for CDC's Division of Nutrition and Physical Activity.

Arthritis and chronic joint symptoms affect nearly 66 million Americans and they are the Nation's leading cause of disability. Early diagnosis and appropriate management of the disease can prevent much of the pain and disability associated it. The CDC Coalition recommends $14.4 million for the arthritis programs of the CDC.

More than 400,000 people die prematurely every year due to tobacco use. The CDC's tobacco control efforts seek to prevent tobacco addition in the first place, as well as help those who want to quit. The CDC Coalition recommends $145 million for the CDC's tobacco control programs.

Each day more than 4,000 young people try their first cigarette. At the same time, daily participation in high school physical education classes dropped from 42 percent in 1991 to 32 percent in 2001. Almost 80 percent of young people do not eat the recommended number of servings of fruits and vegetables, while nearly 30 percent of young people are overweight or at risk of becoming overweight. And every year, almost 800,000 adolescents become pregnant and about 3 million become infected with a sexually transmitted disease. School health programs are one of the most efficient means of correcting these problems, shaping our Nation's future health, education, and social well-being. The CDC Coalition requests $34 million for CDC's Division of Adolescent and School Health (DASH) Coordinated School Health Program and $41.8 million for DASH's HIV prevention education programs.

Public health programs delivered at the State and local level should be flexible to respond to State and local needs. Within an otherwise-categorical funding construct, the Preventive Health and Health Services Block Grant is the only source of flexible dollars for States and localities to address their unique public health needs. The track record of positive public health outcomes from Prevention Block Grant programs is strong, yet so many requests go unfunded. However, the President's budget proposes the elimination of the Preventive Health and Health Services Block Grant—again. We appreciate the work of the subcommittee to at least partially restore the fiscal year 2006 elimination of the Block Grant. Nevertheless, the $20 million cut to the Block Grant in fiscal year 2006 reduces the States' ability to tailor Federal public health dollars to their specific needs. As States use their Prevention Block Grant dollars to address high priority needs such as emerging and chronic diseases, child safety seat programs, suicide prevention, smoke detector distribution and fire safety programs, adult immunization, oral health, worksite wellness, infectious disease outbreaks, food safety, emergency medical services, safe drinking water, and surveillance needs—we can scarcely understand why the Prevention Block Grant should be eliminated. We encourage the subcommittee to restore the cuts and fund the Prevention Block Grant at $132 million.

Much of CDC's work in chronic disease prevention and health promotion is guided by its prevention research activities. Prevention research considers the factors associated with illness, disability, and injury, such as lifestyles or exposure to environmental toxins, and the best ways to address these factors and thereby promote health. By answering these questions, prevention research links biomedical research, which focuses on human physiology and disease treatment, to policies and public health interventions that promote wellness and reduce the need for treatment.

CDC provides national leadership in helping control the HIV epidemic by working with community, State, national, and international partners in surveillance, research, prevention and evaluation activities. The CDC estimates that up to 1,185,000 Americans are living with HIV, one-quarter of whom are unaware of their infection. Also, the number of people living with HIV is increasing, as new drug therapies are keeping HIV-infected persons healthy longer and dramatically reducing the death rate. Prevention of HIV transmission is our best defense against the AIDS epidemic that has already killed over 500,000 U.S. citizens and is devastating the populations of nations around the globe, and CDC's HIV prevention efforts must be expanded. The CDC Coalition recommends that a total of $1.05 billion be appropriated to the Division of HIV Prevention.

The United States has the highest sexually transmitted diseases (STD) rates in the industrialized world. More than 18 million people contract STDs each year. In 1 year, our Nation spends over $8.4 billion to treat the symptoms and consequences of STDs. Elimination of STDs, especially syphilis, is now within our grasp. These welcome opportunities, if adequately funded now, will save millions in annual health care costs in the future. Untreated STDs contribute to infant mortality, infertility, and cervical cancer. State and local STD control programs depend heavily on CDC funding for their operational support.

CDC conducts the National Health and Nutrition Examination Survey (NHANES), the only national source of objective health data to provide accurate estimates of diagnosed and undiagnosed medical conditions in the population. NHANES is a unique collaboration between CDC, the National Institutes of Health (NIH), and others to obtain data for biomedical research, public health, tracking of health indicators, and policy development. Through physical examinations, clinical and laboratory tests, and interviews, NHANES assesses the health status of adults and children in the United States. Mobile exam centers travel throughout the country to collect data on chronic conditions, nutritional status, medical risk factors (e.g., high cholesterol level, obesity, high blood pressure), dental health, vision, illicit drug use, blood lead levels, food safety, and other factors that are not possible to assess by use of interviews alone. Findings from this survey are essential for determining rates of major diseases and health conditions and developing public health policies and prevention interventions.

We must address the growing disparity in the health of racial and ethnic minorities. CDC's REACH 2010 Demonstration Program, Racial and Ethnic Approaches to Community Health (REACH), helps States address these serious disparities in infant mortality, breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and immunizations. We encourage the subcommittee to provide adequate funds for CDC's REACH program.

The CDC Coalition is requesting an appropriation of $49.75 million for Steps to a HealthierUS (STEPS) program. Additional resources will allow for the creation of programs in more States. Furthermore, while the President's budget request in-

cludes $1.5 million to support the YMCA Pioneering Healthier Communities initiative, $3 million is needed to continue to expand this important effort. This would enable additional communities to participate in this initiative, to allow on-going training for communities and to support a Center for Community Health Advancement at the CDC to assist the YMCA and other communities undertaking healthy lifestyle initiatives to prevent and control obesity and chronic disease.

CDC oversees immunization programs for children, adolescents and adults, and is a global partner in the ongoing effort to eradicate polio worldwide. The value of adult immunization programs to improve length and quality of life, and to save health care costs, is realized through a number of CDC programs, but there is much work to be done and a need for sound funding to achieve our goals. Influenza vaccination levels remain low for adults. Levels are substantially lower for pneumococcal vaccination and significant racial and ethnic disparities in vaccination levels persist among the elderly. Childhood immunization programs at CDC also need a funding boost, to ensure sufficient purchase and delivery of the varicella and pneumococcal vaccines. In addition, developing functional immunization registries in all States will be less costly in the long run than maintaining the incomplete systems currently in place. The CDC Coalition requests $802.4 million for the National Immunization Program at CDC.

Injuries are the leading cause of death in the United States for people ages 1–34. Of all injuries, those to the brain are most likely to result in death or permanent disability. Each year more than 50,000 people die as a result of a brain injury and as many as 90,000 others are left with a long-term disability. A traumatic brain injury (TBI) is defined as a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain. The Traumatic Brain Injury Act is the Nation's only law that was specifically designed to respond to this public health crisis. The Institute of Medicine reported this month that this law has been effective in addressing a wide variety of gaps in service system development. The CDC Coalition requests that the subcommittee restore $30 million in appropriations for TBI programs at CDC and at HRSA, which President Bush zeroed out. The monies would be allocated as follows: CDC—$9 million; HRSA State Grant Program—$15 million; and HRSA Protection and Advocacy program—$6 million.

Injury at work remains a leading cause of death and disability among U.S. workers. During the period from 1980 through 1995, at least 93,338 workers in the United States died as a result of injuries suffered on the job, for an average of about 16 deaths per day. The Bureau of Labor Statistics (BLS) at the Department of Labor has identified 5,915 workplace deaths from acute traumatic injury in 2000. BLS also estimates that 5.7 million injuries to workers occurred in 1997 alone; while NIOSH estimates that about 3.6 million occupational injuries were serious enough to be treated in hospital emergency rooms in 1998. The injury prevention and workforce protection initiatives of NIOSH need continued support.

Of the 4 million babies born each year in the United States, 3 percent are born with one or more birth defects. Birth defects are the leading cause of infant mortality, accounting for more than 20 percent of all infant deaths. Children with birth defects who survive often experience lifelong physical and mental disabilities. An estimated 54 million people in the United States currently live with a disability, and 17 percent of children under the age of 18 have a developmental disability. Direct and indirect costs associated with disability exceed $300 billion.

Created by the Children's Health Act of 2000 (Public Law 106–310), the National Center on Birth Defects and Developmental Disabilities (NCBDDD) at CDC conducts programs to protect and improve the health of children and adults by preventing birth defects and developmental disabilities; promoting optimal child development and health and wellness among children and adults with disabilities. We encourage the subcommittee to provide at least $135 million in fiscal year 2007 funding for the NCBDDD. This would be a modest increase of $10 million and would further surveillance, research and prevention activities related to birth defects and developmental disabilities and improve the lives of those living with disabilities.

We also encourage the subcommittee to provide $10 million for CDC's Environmental Public Health Services Branch to revitalize environmental public health services at the national, State, and local level. As with the public health workforce, the environmental health workforce is declining. Furthermore, the agencies that carry out these services are fragmented and their resources are stretched. These services are the backbone of public health and are essential to protecting and ensuring the health and well being of the American public from threats associated with West Nile virus, terrorism, E. coli and lead in drinking water.

We appreciate the subcommittee's hard work in advocating for CDC programs in a climate of competing priorities. We encourage you to consider our request for $8.5

billion, plus sufficient funding to prepare for a possible influenza pandemic, for CDC in fiscal year 2007.

PREPARED STATEMENT OF THE COLLEGE OF NEW ROCHELLE, NY

Mr. Chairman and Members of the subcommittee, on behalf of The College of New Rochelle (CNR), and the thousands of New York City metropolitan area residents impacted by our programs each year, I am grateful for the opportunity to submit testimony to your committee regarding our Center for Wellness project.

THE NATIONAL HEALTH CARE CRISIS: A NEED FOR THE PROJECT

Government sources report that one of the most important issues currently facing American society is the health care crisis. Among the reasons cited are the escalating costs of health care, an increasing lack of access to health insurance among the poor and middle class, an aging population and a growing national shortage of qualified nurses and other health care providers.

Recent data shows the following:

—Out of some 40 million Americans who are informal care givers, an estimated 72 percent are women;

—Women represent 71 percent of Americans age 85+, the fastest growing segment of the population;

—Almost two-thirds of Americans are overweight or obese;

—One in three Americans born in the year 2000 will develop Type 2 diabetes;

—Surveys indicate that 28 percent of high school girls think they are overweight; 60 percent report trying to lose weight; 8 percent suffer from anorexia or bulimia;

—More than half of all Americans get too little physical activity;

—Some 45 million Americans have no health insurance; and

—Over 1 million new and replacement nurses will be needed nationwide by 2020.

One significant health care issue is the individual's lack of attention to participation in self-care. Government experts emphasize the importance of widespread public awareness of basic health habits and preventative care, as well as support for those seeking preventative assistance in making better health and lifestyle choices. In order to keep the crisis from increasing, the U.S. Department of Health and Human Services, through the Office of Disease Prevention and Health Promotion, has launched a national initiative, Healthy People 2010. Through its School of Nursing, and programs such as Healthy Campus 2010, CNR has been participating actively in HHS initiatives for many years, developing local health education programs which benefit students and New York City metropolitan area residents, and which help address national goals.

The Office of Disease Prevention and Health Promotion has identified ten major public health issues based on their causal relationship to serious or chronic illnesses. These are: insufficient physical activity, overweight and obesity, decreasing environmental quality, tobacco use, substance abuse, irresponsible sexual behavior, mental health disorders, injury and violence, immunization deficiencies, and lack of access to health care. People of all socio-economic backgrounds are susceptible; however, the risk factors are even greater among the poor, the elderly and the uninsured.

Moreover, recent studies reveal that those most at risk for developing chronic and life-threatening conditions are African Americans, Hispanics, and Asians—populations largely represented in the New York metropolitan area where CNR has six campus locations serving 7,000 students and many local residents.

THE NATIONAL NURSING SHORTAGE: CNR'S SCHOOL OF NURSING

Compounding the health care crisis is the critical and unprecedented nationwide shortage of nurses—one that is uniquely different from previous shortages. Among the causes cited for this growing problem are an aging nursing workforce, increased job opportunities for women in other fields, and fundamental changes in how and in what setting patients are treated. A compelling statistic is the average age of nurses which is now over 45. A significant percentage of nurses currently employed will most likely retire just as the baby boom generation reaches Medicare age.

According to a recent Federal survey an estimated 1 million new and replacement nurses will be needed nationwide by 2020. Government leaders are stressing the urgency of embarking on a national agenda to encourage more students to choose nursing as a career. Among their recommendations are the creation of incentives to

recruit new candidates to the profession, and the broad-scale development of creative approaches for the continuing preparation and retention of skilled nurses.

CNR's School of Nursing (SON), founded in 1976, belongs to the National League for Nursing and is accredited by the Commission on Collegiate Nursing Education. The School is ideally poised to assume a leadership role in enacting the national recommendations cited above. In recent years, the School has been especially successful in recruiting students (including many from disadvantaged backgrounds) and in fostering a lifelong commitment to nursing careers. Enrollment in SON has increased by 25 percent over the past 2 years. At present, there are 669 students enrolled in SON: 580 in the baccalaureate program and 89 in the masters program. SON programs are addressing the shortage by creating initial student access to the nursing profession and also by providing a career ladder for nurses seeking to advance their careers. Five separate programs are offered:

—Undergraduate program leading to a Bachelor of Science Degree in Nursing (BSN);
—Programs of study for registered nurses seeking either a BSN or a Master of Science Degree;
—BSN program for those holding degrees in other fields;
—Graduate program with several tracks leading to an MS Degree in Nursing; and
—Several post-Master certificate programs.

A pivotal function of CNR's multi-faceted Center for Wellness project includes the building of a new state-of-the-art facility on the College's New Rochelle campus, providing space for nursing and health education classes and events. This will heighten the visibility of nurses as educators as a crucial part of the nursing profession throughout the New York City area and beyond. The new facility and its related health and wellness education programs also hold much promise for drawing a greater number of students to SON as well as providing expanded access and opportunity for nurses seeking to acquire additional professional skills and/or further their careers.

THE CENTER FOR WELLNESS AT THE COLLEGE OF NEW ROCHELLE

The proposed Center for Wellness will be a state-of-the-art multi-purpose facility at the College's main campus and will house Nursing programs, Physical Education, Health Education and Health Services programs. The faculty will create a comprehensive center for the development and delivery of a broad range of integrated health and wellness education programs. The program will include a variety of health and educational activities in an intergenerational fashion to involve students, employees, and members of the surrounding community. Health seminars will cover a wide variety of issues including parenting and women's issues, smoking, diabetes, heart disease, nutrition and weight issues, sex education and assault issues, drug abuse prevention and treatment, and wellness education. The School of Nursing will offer courses and workshops in wellness and disease prevention, not only through the curriculum in the School of Nursing, but also to the students, staff and faculty in Westchester and at the branch campuses. The integrated wellness program will be supplemented with fitness and education programs targeted to specific populations such as the New Rochelle School District, the Senior Center of New Rochelle and the United Hebrew Home.

The programs at the Center for Wellness will provide access to timely information and help foster lifelong healthy lifestyle choices among students, faculty and staff at the main campus and throughout the five metropolitan New York communities where CNR has city campus locations. At these city campuses, CNR will give busy low-income adult students access to wellness promotion, health maintenance and fitness programs on campus. For example, the College is working with the New York City health education program "Take Care New York" to educate all of our students on the necessity of a healthy lifestyle. CNR will also use distance learning technology so that faculty and staff at its campuses can share their own expertise, as well as that of national experts, with CNR students and community members.

The College of New Rochelle recognizes that preventative health care is vital to our Nation's future. This Center will position CNR as a model institution for the development and delivery of innovative health and wellness education. CNR believes that this holistic approach to wellness will serve as motivation for more students to enter the field of nursing and thus begin to alleviate the nursing shortage. The programs, adaptable to the needs of many different communities and populations, will be able to be replicated at other institutions regionally and nationally.

The total cost to establish the Center for Wellness is estimated at $25 million. Through the support of the subcommittee, The College of New Rochelle received funding through the Labor, HHS and Education Appropriations Bill in the amount

of $200,000 in 2005. CNR has utilized this funding for the development of wellness education programs that have benefited CNR students, middle school students, and senior citizens from the area surrounding the New Rochelle Campus. In fiscal year 2007, The College hopes that the subcommittee can fund our request of $2.7 million to construct and equip the Center.

PREPARED STATEMENT OF THE DIABETES CARE COALITION

Mr. Chairman and members of the Committee, thank you for the invitation today to discuss how government, private industry and non-governmental agencies can form innovative partnerships to address the epidemic of uncontrolled diabetes in America. This raging epidemic is simply too great a challenge for any but a collective effort.

I know this subcommittee has little ability to change the fiscal reality that you must produce an appropriations bill that, for a second consecutive year, must reduce spending under your jurisdiction by multiple billions of dollars. This fiscal reality does not change the fact that one out of every three people with diabetes will suffer a heart attack by age 40, every day 144 Americans with diabetes will go blind, every hour three people with diabetes will undergo an amputation, and every minute 20 people with diabetes undergo kidney dialysis. The sad fact is most of these and other complications of diabetes are preventable through known interventions. But, not everyone living with diabetes is aware of some of the simple things they can do to monitor their disease and prevent some of these terrible consequences.

My entire career has been dedicated to improving the care of people with diabetes, through research into the causes of diabetes complications, and how to improve diabetes care. I have been President of the American Diabetes Association, a member of the Coalition I represent today, and the founding Chairman of the private-public partnership of the National Diabetes Education Program (NDEP), which was funded by the National Institutes of Health and the Centers for Disease Control and Prevention (CDC) to improve the care of Americans with diabetes. I am also the Medical Advisor to the Diabetes Care Coalition (DCC) on whose behalf I am speaking today.

As Dr. Gerberding told the House of Representatives Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies in March 2006, "where we invest, we can make a difference". I am here today to tell you that the DCC is committing significant private sector resources to mount a critical public awareness campaign aimed at improving the health of individuals with diabetes. We are initiating discussions with experts at the CDC, and are excited about the potential opportunity to develop an innovative partnership with this world-renown agency to leverage scarce Federal resources, and combine our efforts with theirs, to immediately begin to reduce the burden of this rapidly growing disease.

In this difficult fiscal environment where we are seeing the CDC budget cut this year by hundreds of millions of dollars, and the President's proposal to cut it again by almost $200 million next year, we believe it is imperative to encourage creative solutions to reach the millions of Americans living with diabetes with information that can ultimately prevent heart attacks, strokes, blindness, amputations, and other complications of this disease. The DCC represents what is truly a creative solution to combat the problem of uncontrolled diabetes.

The DCC was born out of a recognition by its various participants that Americans with diabetes lack a basic understanding of how best to control their disease to reduce their risk of complications like heart attacks and strokes. The DCC's pilot "Know Your A1C" campaign represents a novel approach to empower people with diabetes to take personal responsibility by working with their diabetes healthcare team to manage the disease.

Personally, I am concerned that the Federal Government's commitment to battling the epidemic of uncontrolled diabetes is under-funded and potentially losing ground. Since 2003, the CDC estimates that the prevalence of diabetes in America increased 14 percent. Over 20.8 million adult Americans live with diabetes today compared to 18.2 million in 2003. While I recognize the limitations on the Federal budget and the tough choices that have to be made in this Committee every day, now is not the time to approve declining budgets for our Federal programs that aim to prevent and manage diabetes.

I do not want to overwhelm you with facts and figures, but it is clear from even a brief review that diabetes is about to overwhelm America's medical system. By providing you with perspective related to the reach of diabetes, I trust you will appreciate the need to invest in battling uncontrolled diabetes before its impact dev-

astates our health system. The place our Nation needs to make this investment is here in your appropriations bill, in the CDC.

Diabetes strikes across age groups, economic status, and ethnicity. Projections for the future are even more ominous. The Yale Schools of Public Health and Medicine project the population of Americans living with diabetes will increase two and a half times by 2025. Supporting this projection, the CDC estimates that 33 percent of all children and nearly one half of minority children born in the year 2000 will develop diabetes by 2050.

The economic cost of diabetes is enormous. In 2002, the total economic impact of diabetes was $132 billion. Put another way, 1 out of every 10 health care dollars spent in the United States is spent on diabetes care and its complications. CMS estimates that 32 percent of the Medicare budget goes towards caring for Americans with diabetes—an amazing one-third of the entire Medicare program that is struggling with long-term solvency issues far more critical and a near-term fiscal crisis than Social Security solvency.

The human costs of uncontrolled diabetes are more shocking:

—2 out of 3 people with diabetes in America will die of a heart attack or stroke.

—Diabetes is the leading cause of blindness, causing 12,000 to 24,000 new cases each year.

—Diabetes is the leading cause of kidney failure, accounting for 43 percent of new cases in 2002.

—More than 60 percent of non-traumatic lower-limb amputations occur in people with diabetes.

Unfortunately, most diabetes patients are not controlling the risk factors that can keep them healthy. A1C is a compelling example of this trend. A1C is the single most important measure of glucose control over time and a proven risk factor for all major diabetes complications. A1C is a test that shows glucose control over the previous 3 months; sort of a diabetes batting average except that lower is better.

Diabetes patients should know their A1C number and work to keep it in check—similar to blood pressure or cholesterol levels. The test is paid for by managed care, Medicare, and most private insurance plans; there are few financial barriers to being in the know.

However, a recent study by the New York State Department of Health found that 89 percent of patients with diabetes did not know their A1C. Worse, even among those who knew their A1C, 80 percent had A1C's above the value deemed acceptable by all diabetes organizations. Nationally, the CDC estimates that 65 percent of all diabetes patients are out of control, defined by the CDC as "an A1C level above 7."

I urge this Committee to consider, based on the dire state of diabetes in America, whether we can or should continue to overlook the basic diabetes care needs of Americans. The answer to me seems obvious; we must embark on an aggressive campaign to encourage Americans to manage diabetes to control its staggering human and financial costs that encompass all sectors of the American community.

The DCC works to bridge the diabetes management knowledge gap by educating diabetes patients and their healthcare teams on ways to battle uncontrolled diabetes primarily through A1C awareness and management. Through public education in its initial test markets, the DCC aims to help diabetes patients take control of their disease and live longer, healthier lives—without the specter of heart attack, stroke, amputation, or kidney failure.

The American Diabetes Association and the Juvenile Diabetes Research Foundation International are jointly leading the DCC's "Know Your A1C" campaign to battle uncontrolled diabetes in America. Providing financial support to this novel non-branded, public-private partnership are six of the world's leading pharmaceutical and medical device companies: Abbott Diabetes Care Inc., Becton, Dickinson and Company, LifeScan, Inc., Novo Nordisk Inc., Roche Diagnostics Corporation, and sanofi-aventis U.S. Inc.

The "Know Your A1C" campaign is different from other public service campaigns. It encourages Americans and their families to control diabetes by focusing primarily on the message that patients need to know and to manage their A1C. Prior to launching its campaign, the DCC conducted research to determine the most effective way to encourage patients to manage diabetes and the findings supported a sole focus on A1C control.

The campaign utilizes television, radio and print placements to reach families affected by diabetes in the pilot markets. While these placements consist of paid advertising today, beginning in late 2006, most of the effort will rely on public service announcements generated under an agreement with the Ad Council.

The effort is enhanced by the sales teams of the corporate supporters who distribute unbranded educational materials into medical offices, clinical laboratories, pharmacies, diabetes educators' offices and any other location likely to be frequented

by a person with diabetes in the pilot markets. The campaign also provides an order fulfillment system via 800 number allowing people to request basic materials associated with the campaign, a website and direct mail to healthcare professionals to ensure campaign materials have the broadest reach possible in the test markets.

In 2006, the DCC will expand upon its 2005 "Know Your A1C" pilot program in Atlanta and Tampa. This year, the campaign will reach the television and radio markets of Atlanta, GA, Lexington, KY, Little Rock, AR and Memphis, TN.

The DCC is expanding its focused campaign simply because it is proven to work. Consider some of these compelling highlights of the campaign's achievements in 2005 in Atlanta and Tampa.

—An improvement in the number of patients with diabetes who report obtaining an A1C test in the past 3 months from a low of 25 percent prior to campaign launch to an average of 52 percent during the campaign.

—An increase in patient with diabetes understanding of A1C awareness from a low of 38 percent among people with diabetes prior to the launch of the campaign to an average of 54 percent by the end of the campaign; and

—An increase in patient with diabetes understanding of what the A1C test measures from a low of 17 percent prior to the campaign to an average of 41 percent during the campaign.

Based upon these results, the Ad Council will join the DCC to refine the "Know Your A1C" campaign and transform it from a regional effort into a national public service campaign. This campaign is expected to launch in late 2006. Plus, the campaign hopes to reach English and Spanish speaking populations. I hope you share in my enthusiasm for this program as it could potentially transform America's ambivalence towards the uncontrolled diabetes epidemic into a national call to action.

We would like to build on the current NIH and CDC patient awareness campaigns and will soon talk to CDC about the best ways to work with it to improve patient awareness of A1C levels. This may include CDC support for needed patient and healthcare provider components that inform Americans with diabetes how they can and should manage the disease not presently part of the campaign. Components the DCC would like to incorporate in the campaign include more aggressive healthcare provider education tools, documents informing families how to help manage a family member's diabetes, information detailing steps patients can take for A1C control, components that speak more directly to multi-cultural audiences and a more robust order fulfillment program.

While the Diabetes Care Coalition will provide an expanded national "Know Your A1C" campaign in late 2006 and the personnel necessary to distribute the materials associated with the campaign, a partnership with the Federal Government will enable us to expand and enhance our campaign. A public-private partnership will give us the expertise and funding needed to take the battle to all Americans and their healthcare teams to eliminate uncontrolled diabetes. This makes economic and humanitarian sense.

Today, the DCC joins the American Diabetes Association in requesting an increase in the CDC diabetes prevention and control program by $20.8 million in fiscal year 2007. Given the scope and reach of diabetes, we believe this is a modest request even in this budget climate.

We also encourage this Committee to urge the CDC to dedicate new and existing resources for its diabetes control program to battling uncontrolled diabetes. To best serve the American people, CDC must equally address both aspects of controlling this disease—primary prevention activities to stop new cases of diabetes, as well as secondary prevention activities to improve the health of the 20.8 million people living with diabetes.

Members of the Committee, the time to battle the epidemic of uncontrolled diabetes is now. If we miss this opportunity, America will lose substantial ground and run the risk of never getting the diabetes epidemic under control.

Unfortunately, the 20.8 million Americans living with diabetes today represent "the low water mark" in the reach and scope of the disease. It is time to realize that diabetes is here to stay in America and to act in a way that accepts this truth. Please help empower Americans living with diabetes, and the growing numbers who will live with it tomorrow, to "Know Your A1C" by providing the CDC with the resources needed to battle the epidemic of uncontrolled diabetes.

Thank you for your time and consideration.

PREPARED STATEMENT OF THE INTERTRIBAL BISON COOPERATIVE

INTRODUCTION AND BACKGROUND

My name is Ervin Carlson, a Tribal Council member of the Blackfeet Tribe of Montana and President of the InterTribal Bison Cooperative. Please accept my sincere appreciation for this opportunity to submit testimony to the honorable members of the Appropriations Sub-Committee on Labor, Health and Human Services and Education. The InterTribal Bison Cooperative (ITBC) is a Native American nonprofit organization, headquartered in Rapid City, South Dakota, comprised of 57 federally recognized Indian Tribes located within 19 States across the United States.

Buffalo thrived in abundance on the plains of the United States for many centuries before they were hunted to near extinction in the 1800s. During this period of history, buffalo were critical to survival of the American Indian. Buffalo provided food, shelter, clothing and essential tools for Indian people and insured continuance of their subsistence way of life. Naturally, Indian people developed a strong spiritual and cultural respect for buffalo that has not diminished with the passage of time.

Numerous tribes that were committed to preserving the sacred relationship between Indian people and buffalo established the ITBC as an effort to restore buffalo to Indian lands. ITBC focused upon raising buffalo on Indian Reservation lands that did not sustain other economic or agricultural projects. Significant portions of Indian Reservations consist of poor quality lands for farming or raising livestock. However, these wholly unproductive Reservation lands were and still are suitable for buffalo. ITBC began actively restoring buffalo to Indian lands after receiving funding in 1992 as an initiative of the Bush administration.

Upon the successful restoration of buffalo to Indian lands, opportunities arose for Tribes to utilize buffalo for tribal economic development efforts. ITBC is now focused on efforts to assure that tribal buffalo projects are economically sustainable. Federal appropriations have allowed ITBC to successfully restore buffalo the tribal lands, thereby preserving the sacred relationship between Indian people and buffalo. The respect that Indian tribes have maintained for buffalo has fostered a serious commitment by ITBC member Tribes for successful buffalo herd development. The successful promotion of buffalo as a healthy food source will allow Tribes to utilize a culturally relevant resource as a means to achieve self-sufficiency.

FUNDING REQUEST FOR PREVENTATIVE HEALTH CARE INITIATIVE

The InterTribal Bison Cooperative respectfully requests an appropriation for fiscal year 2007 in the amount of $2,000,000 in the form of an earmark to the Department of Health and Human Service Department's budget. ITBC intends to utilize the funds to conduct a national demonstration project focused on the delivery of bison meat to Native Americans suffering from diet related diseases.

The Native American population currently suffers from the highest rates of Type 2 diabetes. The Indian population further suffers from high rates of cardio vascular disease and various other diet related diseases. Studies indicate that Type 2 diabetes commonly emerges when a population undergoes radical diet changes. Native Americans have been forced to abandon traditional diets rich in wild game, buffalo and plants and now have diets similar in composition to average American diets. More studies are needed on the traditional diets of Native Americans versus their modern day diets in relation to diabetes rates. However, based upon the current data available, it is safe to assume that disease rates of Native Americans are directly impacted by a genetic inability to effectively metabolize modern foods. More specifically, it is well accepted that the changing diet of Indians is a major factor in the diabetes epidemic in Indian Country.

Approximately 65–70 percent of Indians living on Indian Reservations receive foods provided by the USDA Food Distribution Program on Indian Reservation (FDPIR) or from the USDA Food Stamp Program. The FDPIR food package is composed of approximately 58 percent carbohydrates, 14 percent proteins and 28 percent fats. Studies have shown that the FDPIR food package has not been compatible with the genetic compositions of Native Americans and has been a major factor in the high incidence of diet-related disease among Native Americans. Indians utilizing Food Stamps generally select a grain based diet and poorer quality protein sources such as high fat meats based upon economic reasons and the unavailability of higher quality protein food sources.

Buffalo meat is low in fat and cholesterol and is compatible to the genetics of Indian people. ITBC intends to develop a health care initiative that would educate Indian Reservation families of the benefits of incorporating buffalo meat into their diets. In conjunction with educating Reservation families on the benefits of buffalo meat, ITBC intends to develop methods to make buffalo meat accessible for Indian

families and to promote incorporation of buffalo into their diets. ITBC intends to coordinate with Reservation health care providers in nutritional studies of Reservation populations that incorporate buffalo meat into diet packages.

ITBC believes that incorporating buffalo meat will positively impact the diets of Indian people living on Reservations. A healthy diet for Indian people that results in a lower incidence of diabetes and other diet related illnesses will reduce Indian Reservation health care costs and result in a savings for taxpayers.

FUNDING REQUEST FOR ITBC TRAINING AND LABOR PROGRAM

The InterTribal Bison Cooperative respectfully requests an appropriation for fiscal year 2007 in the amount of $500,000. This amount is $400,000 above the fiscal year 2006 appropriation for ITBC and is critical to maintain last years funding level and to develop ITBC's training and labor program.

In fiscal year 2005, the ITBC and its member Tribes were funded at $100,000, a decrease of $200,000 from the previous year. ITBC is now requesting $500,000 for fiscal year 2007 for job training as part of ITBC's labor initiative. To insure the success of ITBC' s buffalo restoration efforts to Indian lands, training for the various jobs related to the buffalo projects is essential. Most member Tribes of ITBC have reservation unemployment rates of 72 percent. Jobs opportunities on most Indian Reservations are limited, low-paying, and often seasonal and temporary. The jobs created by buffalo restoration to Indian lands will positively impact Tribal unemployment rates and the overall Reservation poverty levels. Raising buffalo as an economic development effort requires skilled labor in permanent employment. ITBC has developed a job training program incorporating on-the-job training and work experience for youth that specifically addresses the unique needs of managing and maintaining buffalo. ITBC's training program further focuses on strengthening the economic development opportunities of buffalo restoration with training specific to meat processing, veterinary science, wildlife and biological services, infrastructure development, business and management training, and the overall development of a skilled workforce.

Sufficient funding for job training is critical to the success of the buffalo restoration projects. The increase in funding will ensure that ITBC can provide job training, job growth training to ITBC member tribes. Without funding at the requested level, the buffalo restoration projects have less assurance of success.

ITB GOALS AND INITIATIVES

In addition to developing a preventative health care initiative, ITBC intends to continue with buffalo restoration efforts and the Tribal buffalo marketing initiative.

In 1991, seven Indian Tribes had small buffalo herds, with a combined total of 1,500 animals. The herds were not utilized for economic development but were often maintained as wildlife only. During ITBC's relatively short 10-year tenure, it has been highly successful at developing existing buffalo herds and restoring buffalo to Indian lands that had no buffalo prior to 1991. Today, through the efforts of ITBC, over 35 Indian Tribes are engaged in raising over 15,000 buffalo. All buffalo operations are owned and managed by Tribes and many programs are close to achieving self-sufficiency and profit generation. ITBC's technical assistance is critical to ensure that the current Tribal buffalo projects gain self-sufficiency and become profit-generating. Further, ITBC's assistance is critical to those Tribes seeking to start a buffalo restoration effort.

Through the efforts of ITBC, a new industry has developed on Indian reservations utilizing a culturally relevant resource. Hundreds of new jobs directly and indirectly revolving around the buffalo industry have been created. Tribal economies have benefited from the thousands of dollars generated and circulated on Indian Reservations.

CONCLUSION

ITBC has proven highly successful since its establishment to restore buffalo to Indian Reservation lands to revive and protect the sacred relationship between buffalo and Indian Tribes. Further, ITBC has successfully promoted the utilization of a culturally significant resource for viable economic development.

ITBC has assisted Tribes with the creation of new jobs, on-the-job training and job growth in the buffalo industry resulting in the generation of new money for tribal economies. ITBC is also actively developing strategies for marketing Tribally owned buffalo. Finally, and most critically for Tribal populations, ITBC is developing a preventive health care initiative to utilize buffalo meat as a healthy addition to Tribal family diets to reduce the incidence of diet-related illnesses.

ITBC strongly urges you to support its request for a $2,000,000 earmark to the Department of Health and Human Service Department's budget to develop the critically needed preventative health care initiative utilizing Tribally produced buffalo.

PREPARED STATEMENT OF THE JOHN B. AMOS CANCER CENTER

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to submit testimony to the hearing record regarding the John B. Amos Cancer Center (JBACC) in Columbus, Georgia. JBACC is a comprehensive community cancer center designed to address the continuum of the disease from prevention and early detection through treatment, survivorship and palliation.

Accredited by the Commission on Cancer, American College of Surgeons, JBACC's mission is to provide exceptional quality-driven care. Accordingly, we have opened a (49,620 sq. ft.) hospital-based cancer center located on its own campus and surrounded by meditation gardens. This unique facility is designed to address cancer along a disease management approach allowing patients, families, and the community at large to enter our services at any point in the disease process whether it is for education, diagnosis, treatment, or psychosocial support. Our outreach programs are a significant component of our action plan to improve the health of the region, as well. Further development of these programs is the reason I address you today.

As you are aware, the John B. Amos Cancer Center received fiscal year 2005 Labor, HHS, and Education Appropriations. I would like to thank the subcommittee for this support and elaborate on the success of our programs thus far.

Leveraging community and government support, we have developed extensive Breast and Cervical Cancer Screening Programs that allow us to reach many underserved areas of the 14 county region encompassing our service area. Community Health Advisors (CHAs) trained and educated by JBACC in collaboration with the West Georgia Cancer Coalition to address cancer education, prevention, and diagnostic care, assist in the facilitation of community screenings to maximize the effect of the screening events. These CHAs are native to the communities they serve and therefore possess intuitive knowledge necessary for conducting successful community screenings such as appropriate venues and marketing techniques for the respective population. Other factors, such as matching a bilingual CHA with Hispanic communities to increase accessibility and comfort levels are also considered.

Screenings are conducted on a weekly basis in communities throughout the region. Rural communities are specifically targeted as screening sites at least once a month. A culturally diverse multidisciplinary team extends a comprehensive approach to providing care and access to services at these events. This is a level of service previously unattainable in some areas. The team includes a bilingual physician, a nurse practitioner, a nurse, a case manager, and clerical personnel. Additionally, volunteers are often available to set up educational materials. The CHAs often attend the events as well and may sometimes act as liaisons between patients and the JBACC staff.

By the point at which many patients walk into the Amos Cancer Center facility, the disease has advanced to a stage at which treatment and cure is exceedingly difficult. Therefore, the primary goal of community screenings is to promote and make available early detection and treatment options. To this end, initial on-site exams are performed free of charge, regardless of ability to pay, to increase service accessibility. Abnormal exams are referred to care coordinators for referral for additional screenings or diagnostic testing, as applicable. Dependent upon the patient's schedule, this can usually be achieved with the same week as the initial screening. A surgical consult is provided 2 to 4 days after testing, if necessary. If further investigation is warranted, coordinators access the system to see that the patient's needs, including financial and psychological are met. The target timeline objective is two weeks from exam to diagnosis and treatment. Identification of cervical abnormalities is slightly more involved and requires a timeline of approximately 3.5 to 4 weeks.

The outreach program is not limited to screenings. Educational programs and cancer prevention programs are provided to organizations throughout the region. These include breast health lectures provided to churches, sororities, and healthcare groups, and providing educational materials and interactive displays for cancer-themed events on local college campuses. These events reinforce the importance of early detection.

We have developed a successful early detection outreach program. The requested funding of $2 million in fiscal year 2007 would allow us to expand the program to be even more effective within the fourteen county region in which 511,736 citizens reside. Expansion efforts would allow us to reach traditionally underserved popu-

lations by scheduling screenings in communities not yet familiar with our programs. This includes rural and urban areas in both Georgia and Alabama, some of which lie in the socio-economically deprived "Black Belt".

In addition to the community screenings, funding would provide for the development of two permanent weekly cancer screening clinics. These clinics would allow citizens the peace of mind of the availability of set screening opportunities, rather than waiting for a local opportunity to occur.

Funding from JBACC's fiscal year 2005 Labor, HHS, Education Appropriation was limited to breast and cervical cancer screening. However, we have identified a need and an opportunity within the community to focus on men's health issues as well, through prostate screenings. The requested funding would allow for the expansion of our outreach program to include this component. Incorporation of prostate screenings into our existing program could occur seamlessly. This would allow us to expand our focus to include a population previously not served in this capacity. Excluding skin cancers, prostate cancer is the most common cancer in American men. While the statistics regarding prostate cancer are staggering, early detection and more effective treatment methods have led to lower death rates in recent years. This further underscores the need for prostate screening programs in underserved areas to improve the health status of the region.

The requested funding would also provide for colorectal screenings. This year, nearly 150,000 men and women will be diagnosed with colorectal cancer while approximately 56,000 will die from it. Once again, however, early detection and treatment are essential to increased survival rates. However, studies indicate that many people are often uncomfortable talking about the disease. They are also misguided on their risk factors and chance of getting the disease. Overcoming these obstacles to diagnosis and treatment can be achieved through community educational and screening opportunities.

Mr. Chairman, John B. Amos Cancer Center is committed to improving the health of the region by addressing and embracing the Healthy People 2010 focus areas of overall cancer deaths. Recognizing that to reach our goals we must design programs that engage the region in our early detection and screening programs, we have taken great strides to do so. We believe in the documented success of our outreach programs and hope that the subcommittee will provide $2 million toward program expansion. Through the expansion, we will reach underserved populations and reduce cancer mortality and morbidity, thereby improving the health of the region in accordance with the goals of the Department of Health and Human Services as well as this subcommittee.

PREPARED STATEMENT OF MATRIA HEALTHCARE

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS

—Provide full funding in fiscal year 2007 for the Health and Human Services (HHS) Health Information Technology Initiative, including funding for the Office of the National Coordinator for Health Information Technology (ONCHIT) and the Agency for Healthcare Research and Quality (AHRQ).

—Provide a 5 percent increase for fiscal year 2007 to the National Institutes of Health (NIH) budget. Within NIH, provide an increase of 5 percent to the National Library of Medicine (NLM).

—Urge the National Coordinator for the Office of the National Coordinator for Health Information Technology (ONCHIT), the National Library of Medicine (NLM) at the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), and the Centers for Medicare and Medicaid Services (CMS) to conduct outreach activities to all public and private sector organizations which have demonstrated capabilities in health information technology, particularly to those who have demonstrated capabilities in disease management technology as it relates to saving health care dollars, and improving care for chronically ill individuals and the workforce.

Chairman Specter and members of the subcommittee, thank you for the opportunity to present this written statement regarding the importance of health information technology, specifically as it relates to disease management technology, saving health care dollars, and improving care for chronically ill individuals and the workforce.

Matria Healthcare is a national leader in disease management. Our disease management programs have been adopted by leading corporations, health plans, and State governments as a proven solution for reducing costs and improving health and productivity. Because 15 percent of the population typically drives 85 percent of

healthcare costs, Matria believes the strongest, most effective healthcare solutions start with a strong disease management program to begin curbing costs immediately.

The disease management component of Matria's health enhancement offering provides management programs for the Nation's most costly chronic diseases, episodic conditions, and issues affecting the psychosocial well-being of patients and has produced outcomes like no other provider. Matria's industry-leading TRAX technology platform represents the state-of-the-art in healthcare data warehousing and protocol-driven healthcare delivery. This platform is driving the clinical and financial outcome success of Matria in over one hundred Fortune 1000, health plan, and State government programs. Matria's technology platform is being utilized by members of the National Coordinator for Health Information Technology's Interoperability Consortium to successfully improve clinical outcomes and reduce healthcare expenditures amongst its employees.

In April 2004, President Bush revealed his vision for the future of healthcare in the United States. The President's plan involves a health care system that puts the needs of the patient first, is more efficient, and is cost-effective. At this time, he established, within the Office of the Secretary of Health and Human Services, an Office of the National Coordinator for Health Information Technology (ONCHIT). Among other things, this office is meant to ensure that appropriate information is available to guide medical decisions, improve healthcare quality, reduce healthcare costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information, promote a more efficient marketplace, greater competition, and increase in choice, and improve the coordination of care and information among hospitals, laboratories, physician offices, and other ambulatory care providers.

Matria's health enhancement offerings are consistent with these goals of the President and the ONCHIT. In the transition towards a health care system where informed consumers will own their personal health records, health savings accounts, and health insurance, it is important for the Federal Government to partner with public and private sector organizations which have demonstrated capabilities in this arena.

Health information technology will improve the practice of medicine and make it more efficient. The rapid implementation of secure and interoperable electronic health records will, for example, significantly improve the safety, quality, and cost-effectiveness of health care. To implement this vision, Matria urges the subcommittee to support the President's budget request of $116 million for the ONCHIT to provide strategic direction for development of a national interoperable health care system. Matria also encourages the subcommittee to support the $50 million Health Information Technology Initiative through the Agency for Healthcare Research and Quality (AHRQ) to accelerate the development, adoption, and diffusion of interoperable information technology in a range of health care settings. Additionally, Matria urges the subcommittee to provide a 5 percent increase for fiscal year 2007 to the National Institutes of Health (NIH) budget, and within NIH, provide a proportional increase of 5 percent to the National Library of Medicine (NLM).

Finally, Matria encourages the subcommittee to urge the National Coordinator for the ONCHIT, NLM, AHRQ, and the Centers for Medicare and Medicaid Services (CMS) to conduct outreach activities to all public and private sector organizations which have demonstrated capabilities in health information technology, particularly to those who have demonstrated capabilities in disease management technology as it relates to saving health care dollars, and improving care for chronically ill individuals and the workforce.

By working together, the goal of creating an efficient national healthcare system will be realized. Thank you for allowing me to submit this testimony to you today.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE TO END HOMELESSNESS

The National Alliance to End Homelessness (the Alliance) is a nonpartisan, nonprofit organization that has several thousand partner agencies and organizations across the country. These partners are local faith-based and community-based nonprofit organizations and public sector agencies that provide homeless people with shelter, transitional and permanent housing, and services such as substance abuse treatment, job training, and health and mental health care. In addition, we have supported over 220 State and local entities as they create 10 year plans to end homelessness. The Alliance represents a united effort to address the root causes of homelessness and challenge society's acceptance of homelessness as an inevitable by-product of American life.

Overview.—Adequate social services program funding is essential to ending homelessness. Housing must be coupled with appropriate services such as health care, employment preparation, mental health and substance abuse treatment, child care, and youth directed programs to be effective. These programs were put to the test as social service agencies assisted Katrina evacuees. The Social Services Block Grant, the Community Services Block Grant, Projects for Assistance in Transition from Homelessness, Education for Homeless Children and Youth funded school liaisons and Health Care for the Homeless clinics among others were essential as the gulf coast residents overcame their housing crisis. These lessons illustrate how HHS, Labor, and Education programs can help those homeless due to other crises such as job loss or catastrophic illness.

GOALS

1. *Moving Forward to End Homelessness*.—By implementing 10 year plans to end homelessness, communities across America are ending homelessness. Communities are using Federal, State, and local funds to help homeless persons, some of whom have been homeless for years, maintain housing. It is important that this progress not be undermined. To this end, the Alliance recommends the following:

A. Allocate $55 million for services in permanent supportive housing within SAMHSA's Center for Mental Health Services.

B. Reject cuts to the Grants for the Benefit of Homeless Individuals/Treatment for Homeless Individuals (GBHI) and insure that additional local programs can access these funds.

C. Increase funding to Projects for Assistance in Transition from Homelessness (PATH) to $65 million.

D. Increase the Runaway and Homeless Youth Act Programs to $140 million and reject detrimental policy recommendations.

E. Fund Education for Homeless Children and Youth services at its full authorized level of $70 million.

F. Increase funding for the Homeless Veterans Reintegration Program to $50 million.

2. *Connecting Homeless Families, Individuals, and Youth to Mainstream Services*.—The estimated 3.5 million people who are homeless throughout a year depend on mainstream programs such as the ones below to live day to day and once housed, remain housed. These programs help address the complex situations persons experiencing homelessness are trying to overcome. The Alliance recommends the following to meet this goal:

A. Fund the Social Services Block Grant at $1.7 billion, the same funding level as fiscal year 2006.

B. Reject elimination of the Community Services Block Grant.

C. Appropriate $171 million for the Health Care for the Homeless programs within the Health Resource Services Administration's Consolidated Health Centers program.

D. Appropriate $60 million in education and training vouchers for youth exiting foster care under the Safe and Stable Families Program.

Goal #1—Moving Forward to End Homelessness

Support Services for Permanent Supportive Housing Projects

The Alliance recommends allocating $55 million for services in permanent supportive housing within SAMHSA's Center for Mental Health Services. The administration has set a goal of ending chronic homelessness by 2012. We know this goal is attainable based on evidence based practices. For example, through the collaborative initiative grants program, HHS, the Department of Veterans Affairs, and HUD have funded programs and seen results. These eleven grants have ended homelessness for 550 people who cumulatively had over 5,000 years of homelessness. Unfortunately, funding for these grants will end in 2006. The President has proposed an increase of $209 million for the McKinney/Vento homelessness programs as part of the proposed fiscal year 2007 HUD budget to primarily pay for housing for those who are chronically homeless. No such investment has been included for HHS.

Treatment for Homeless Individuals

The Alliance recommends that Congress fully reject cuts in Grants for the Benefit of Homeless Individuals (GBHI) funding and work to strengthen the program for additional grantees. Maintaining programs such as GBHI is essential to achieving the President's goal of ending chronic homelessness by 2012. Mainstream health, welfare, addiction, and mental health programs often do not adequately serve homeless

people. In 2003, the U.S. Department of Health and Human Services studied mainstream programs and their ability to serve chronically homeless populations. The report, entitled Ending Chronic Homelessness: Strategies for Action, explained that no mainstream program is comprehensive enough to adequately serve chronically homeless people. Thus, HHS included in the recommendations that future program budgets should focus on funding programs directed for chronic homelessness.

There are a variety of reasons mainstream programs fail to adequately service people who are chronically homeless. Many programs simply lack the ability to fund or coordinate the full range of health, housing, and support services required to adequately help homeless people. Grants through the Treatment for Homeless Individuals/Grants for the Benefit of Homeless Individuals (GBHI) program help homeless service providers assemble services that meet the complex needs of their clients and maintain their housing.

Projects for Transition Assistance from Homelessness (PATH)

The Alliance recommends that Congress increase PATH funding to $65 million. The PATH program provides homeless people with serious mental illnesses access to mental health services. PATH focuses on outreach to eligible consumers, followed by help in ensuring that those consumers are connected with mainstream services. Under the PATH formula grant, approximately 30 States share in the program's annual appropriations increases. The remaining States and territories receive the minimum grant of $300,000 for States and $50,000 for territories. These amounts have not been raised since the program was authorized in 1991. To account for inflation, the minimum allocation should be raised to $600,000 for States and $100,000 for territories. Amending the minimum allocation requires a legislative change. If the authorizing committees do not have sufficient time to address this issue, we hope that appropriators will explore ways to make the amendment through appropriations bill language.

Runaway and Homeless Youth Programs

The Alliance recommends funding the Runaway and Homeless Youth Act (RHYA) programs at $140 million. RHYA programs support cost-effective, community and faith-based organizations that protect youth from the harms of life on the streets. The problems of homeless and runaway youth are addressed by the Administration for Children and Families within HHS, which operates coordinated competitive grant programs like RHYA. The RHYA programs can either reunify youth safely with family or find alternative living arrangements. RHYA programs end homelessness by: engaging youth living on the street with Street Outreach Programs, quickly providing emergency shelter and family crisis counseling through the Basic Centers, or providing supportive housing that helps young people develop lifelong independent living skills through Transitional Living Programs.

Education for Homeless Children and Youth

The Alliance recommends funding Education for Homeless Children and Youth (EHCY) at its full authorized level of $70 million. The most important potential source of stability for these children is school. The mission of the Education for Homeless Children and Youth program is to ensure that homeless children can continue to attend school and thrive. A struggle for homeless service providers who serve families with children is to maintain the children's stability during a time when their lives are turned upside down. Even if new housing can be found in a short time, the lasting effects of a spell of homelessness can be devastating.

The Education for Homeless Children and Youth program, within the Department of Education's Office of Elementary and Secondary Education, removes obstacles to enrollment and retention by establishing liaisons between schools and shelters and providing funding for transportation, tutoring, school supplies, and the coordination of statewide efforts to remove barriers.

Homeless Veterans Reintegration Program (HVRP)

The Alliance recommends that Congress increase HVRP funding to $50 million. HVRP, within the Department of Labor's Veterans Employment and Training Service (VETS), provides competitive grants to community-based, faith-based, and public organizations to offer outreach, job placement, and supportive services to homeless veterans. HVRP is the primary employment services program accessible by homeless veterans and the only targeted employment program for any homeless subpopulation. The Department of Labor estimates that 8,750 homeless veterans will be served through HVRP at the fiscal year 2006 appropriation level of $22 million. This figure represents just 2 percent of the overall homeless veteran population, which the Department of Veterans Affairs estimates numbers more than 400,000 over the course of a year. An appropriation at the authorized level of $50

million would enable HVRP grantees to reach approximately 19,866 homeless veterans.

Goal #2—Connecting Homeless Families, Individuals and Youth to Mainstream Services

Social Services Block Grant (SSBG)

The Alliance recommends that Congress fully restore SSBG funding to its fiscal year 2006 level of $1.7 billion. Cuts to programs like the SSBG will create additional barriers for communities trying to achieve the President's goal of ending chronic homelessness by 2012. SSBG funds are essential for programs dedicated to ending homelessness. In particular, youth housing programs and permanent supportive housing providers often receive State, county, and local funds which originate from the SSBG. As the U.S. Department of Housing and Urban Development has focused its funding on housing, programs that provide both housing and social services have struggled to fund the service component of their programs. This gap is often closed using Federal programs such as SSBG.

Community Services Block Grant (CSBG)

The Alliance recommends that Congress fully restore CSBG funding to its fiscal year 2006 level of $630 million. Eliminating funding for the CSBG will destabilize the progress communities have made toward ending homelessness by not only ending services directly provided by CSBG funds but limiting a community's ability to access other Federal dollars such as those provided by HUD. This runs contrary to the President's stated goal of ending chronic homelessness by 2012. Community Action Agencies (CAAs) are directly involved in housing and homelessness services. In several communities, CAAs lead the Continuum of Care (CoC). CoCs coordinate local homeless service providers and the community's McKinney-Vento Homeless Assistance Grant application process with the Department of Housing and Urban Development.

In the fiscal year 2004 Community Services Block Grant Information Systems report published by the U.S. Department of Health and Human Services, CAAs reported administering $207.4 million in Section 8 vouchers, $30 million in Section 202 services [1] and $271.1 million in other Department of Housing and Urban Development (HUD) programs which includes homeless program funding.[2]

Health Care for the Homeless (HCH)

The Alliance recommends $171 million, the amount recommended by the President, for HCH (8.7 percent of the $1.963 billion requested for the Consolidated Health Centers account). Persons living on the streets suffer from health problems resulting from or exacerbated by the conditions of being homeless, such as hypothermia, frostbite, and heatstroke. In addition, they often have infections of the respiratory and gastrointestinal systems, tuberculosis, vascular diseases such as leg ulcers, and hypertension.[3] Health care for the homeless programs are vital to prevent these conditions from becoming fatal. Congress allocates 8.7 percent of the Consolidated Health Centers account for Health Care for the Homeless (HCH) projects. The HCH program has achieved significant success since its inception in 1987, but the health care needs Americans experiencing homelessness each year far exceed the service capacity of Health Care for the Homeless grantees. The President's fiscal year 2007 budget would create 15 to 20 new projects, serving an additional 25,000 to 30,000 people experiencing homelessness.

Foster Youth Education and Training Vouchers

The Alliance recommends that Congress appropriate $60 million in education and training vouchers for youth exiting foster care under the Safe and Stable Families Program. The Education and Training Voucher Program offers funds to foster youth and former foster youth to enable them to attend colleges, universities and vocational training institutions. Students may receive up to $5,000 a year for college or vocational training education. The funds may be used for tuition, books, housing, or other qualified living expenses. Given the large number of people experiencing homelessness who have a foster care history, it is important to provide assistance such as these education and training vouchers to stabilize youth, prevent economic crisis, and prevent possible homelessness.

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[1] Section 202 is dedicated to housing from elderly and disabled individuals and families.

[2] U.S. Department of Health and Human Services, Administration of Children and Families. The Community Services Block Grant Fiscal Year 2004 Statistical Report. Prepared by the National Association for State Community Services Programs.

[3] Harris, Shirley N, Carol T. Mowbray and Andrea Solarz. Physical Health, Mental Health and Substance Abuse Problems of Shelter Users. Health and Social Work, Vol. 19, 1994.

CONCLUSION

Homelessness is not inevitable. As communities implement plans to end homelessness, they are struggling to find funding for the services homeless and formerly homeless clients need to maintain housing. The Federal investments in mental health services, substance abuse treatment, employment training, youth housing, and case management discussed above will help communities create stable housing programs and change social systems which will end homelessness for millions of Americans.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

On behalf of more than 1,000 health center grantees across the country serving more than 15 million patients, the National Association of Community Health Centers (NACHC) is pleased to submit this statement for the record, and thank the subcommittee for its continued support and investment in the Health Centers program.

ABOUT HEALTH CENTERS

Over more than 40 years, the Health Centers program has grown from a small demonstration project providing desperately needed primary care services in underserved communities to one of the fundamental elements of our Nation's health care safety net. Funding was approved in 1965 for the first two neighborhood health center demonstration projects, one in Boston, Massachusetts, and the other in Mound Bayou, Mississippi.

Today, America's health centers are helping communities meet escalating health needs and address costly and devastating health problems, from prenatal and infant health development to chronic illness (like diabetes and asthma), to mental health, substance addiction, domestic violence and HIV/AIDS. Health centers are the family doctor for 1 in 8 uninsured individuals, and 1 in every 5 low-income children. Health centers serve as the primary health care safety net for many communities across the country and the Federal grant program enables more low-income and uninsured patients to receive care each year.

Every Federally Qualified Health Center (FQHC) is governed by a community board with a patient majority—a true patient democracy. Health centers are required to be located in a federally designated Medically Underserved Area (or MUA), and must provide a package of comprehensive primary care services to anyone who comes in the door, regardless of their ability to pay. At the typical health center, roughly one-quarter of the operating revenues are from the Federal grant; and just over 40 percent are from reimbursement through Federal insurance programs, principally Medicare and Medicaid. The balance of the revenues are from State and community partnerships, privately insured individuals, and patients ability to pay.

The Health Centers program is administered by the Bureau of Primary Health Care (BPHC) at the Health Resources and Services Administration (HRSA), within the U.S. Department of Health and Human Services (HHS).

FUNDING BACKGROUND

The subcommittee has approved substantial funding increases for the Consolidated Health Centers program over the past several years resulting in a broad expansion effort to serve many of those that remain underserved in our country. Most recently, the increase in funding approved for fiscal year 2006 will help more than 600,000 additional Americans gain access to effective, affordable primary and preventive care services offered by our Nation's Health Centers.

Since 2001, the subcommittee has increased funding for Health Centers in order to stabilize existing centers and meet the goals of the President's initiative—1,200 new or expanded centers and an additional 6.1 million patients served by 2006. To date, the expansion has brought high-quality services to an additional 4 million Americans and has produced new or expanded facilities in over 800 communities nationwide. Even with the increases provided over the past several years, hundreds of communities submitted applications that received high ratings but could not be funded, due to lack of funds. There is clearly a tremendous need and a tremendous desire to expand health center services to new communities.

The health centers program has succeeded in expanding access to primary and preventive care services in underserved communities across the country. The Office of Management and Budget rated the Health Centers program as one of the top 10 Federal programs, and the best competitive grant program within all of HHS. With

additional resources, health centers stand ready to provide low-cost, highly effective care to millions more uninsured and underserved individuals and families.

FISCAL YEAR 2007

In his fiscal year 2007 budget proposal, President Bush requested an increase for the Health Centers program of $181 million, for a total funding level of $1.963 billion in fiscal year 2007. NACHC strongly supports the President's requested increase for the program, which will continue the historic expansion of the Health Centers program into hundreds of additional communities nationwide.

In 2005, President Bush called for "a community health center in every poor county" in America. NACHC strongly supports this goal and urges Congress to provide funds to begin this critical expansion effort. NACHC was encouraged that the administration did not recommend waiving the statutorily designated proportionality requirements for Migrant, Public Housing and Homeless Health Centers in order to implement this second expansion initiative.

In addition to the expansion efforts, it is critical that Federal funding for health centers keep pace with the growing cost of delivering care. NACHC requests that the subcommittee designate $50 million of any increase in funding to be used to make base grant adjustments for existing centers, allowing an average increase of 2.8 percent in current health center grants, equal to the Medicare Economic Index. Under the subcommittee's leadership, Congress has provided base grant adjustments for existing centers in 5 out of the 7 previous fiscal years. A recent study by NACHC found that in the 2 years that these adjustments were not included in the Health Centers appropriation, the number of patient visits per grantee actually decreased.

NACHC appreciates the subcommittee's leadership in stabilizing the Federal Tort Claims Act (FTCA) judgment fund for health centers in past years. For fiscal year 2007, the President has requested that $44,500,000 be appropriated for this purpose. This is the same funding level as last year, and NACHC expects it will be sufficient to cover FTCA claims in 2007.

In 1997, Congress authorized and began funding the HRSA Loan Guarantee Program (LGP) for the construction, renovation, and modernization of health centers. Demand for this guarantee program has accelerated significantly in the last year. NACHC expects that at the current rate of usage, the remaining $5 million in credit subsidy will be entirely used during fiscal year 2006. In response that the success of this program, NACHC is requesting an additional $5 million be provided until expended for additional loan guarantees. The LGP has proven to be a vital resource for health centers across the country as they seek financing to fund the facilities necessary to accommodate the growth in patient visits resulting from recent expansion efforts.

Finally, Health Centers support funding for other Federal programs that are integral to the continued expansion and strength of community health centers. These include:

—$150 million for the National Health Service Corps, which is the largest source of health professionals for health centers;

—$250 million for Title III of the Ryan White CARE Act, which provides grants to health centers and other safety net providers for outpatient early intervention services;

—$550 million for Title VII and Title VIII Health Professions programs, particularly Area Health Education Centers, which bring together academic and community partners to improve the supply and distribution of health professionals in underserved communities.

—$170 million for health information technology (HIT) resources through various programs at the Department of Health and Human Services. Health centers must have adequate resources through HHS to facilitate the utilization of electronic health records and other important HIT tools to promote health disparities reduction.

CONCLUSION

America's health centers are grateful to the subcommittee for its ongoing efforts to support and stabilize the Health Centers program and to expand health centers' reach into more than 5,000 communities nationwide. As a result of those efforts, more than 15 million people have access to the affordable, effective primary care services that our Nation's health centers provide.

We respectfully ask that the subcommittee continue that investment, as the work of caring for our uninsured and medically underserved is far from complete. Some 36 million Americans are still without regular access to medical services. America's

health centers look forward to meeting that need and rising to the challenge of providing a health care system that works for all Americans. We look forward to working with you over the coming year to move toward that goal.

If you need any additional information or have any questions related to health centers or NACHC, please do not hesitate to contact me or John Sawyer, Assistant Director of Federal Affairs, at (202) 331–4603, or via email at jsawyer@nachc.com.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION FOR STATE COMMUNITY SERVICES PROGRAMS

The National Association for State Community Services Programs (NASCSP) thanks this committee for its continued support of the Community Services Block Grant (CSBG), and seeks an appropriation of $650 million for the State grant portion of the CSBG, the same as its fiscal year 2004 appropriation. We are requesting that the CSBG funding be restored to the fiscal year 2004 level this year in order for the CSBG Network to continue addressing the long-term needs of those families affected by Hurricanes Katrina and Rita, those families transitioning from welfare to work, and to assist low-income workers in remaining at work through supportive services such as transportation and child care. It is essential that the CSBG funding be restored in full for fiscal year 2007. The across the board cuts the CSBG has experienced the past several years have decreased the ability of the CSBG Network to provide essential services to low-income Americans.

In addition, NASCSP urges this Committee to eliminate all authorization language regarding the management of the CSBG from the fiscal year 2007 appropriation bill. In fiscal year 2006, the appropriations bill included authorization language regarding the use of the block grant at the State level. Specifically, the fiscal year 2006 appropriations report included the following authorization language which conflicted with "SEC. 675C. USES OF FUNDS (A)(3) of the Public Law 105–285: The Community Opportunities, Accountability, and Training and Educational Services Act of 1998 (the CSBG authorization law): "That to the extent Community Services Block Grant funds are distributed as grant funds by a State to an eligible entity as provided under the Act, and have not been expended by such entity, they shall remain with such entity for carryover into the next fiscal year for expenditure by such entity consistent with program purposes."

The 1998 CSBG Authorization allows CSBG eligible entities to carry over up to 20 percent of funds but requires the State to recapture or redistribute any funds that exceed 20 percent. According to the 1998 CSBG Authorization, once these funds are recaptured the State is to redistribute the excess funds to other low-income communities in dire need of additional funds. When language such as the above is placed in the Appropriations document, it overrides the Authorization language. The inclusion of such language in the appropriations report caused a hardship on States as they managed the block grant. Passing national legislation which contradicts the authorization language regarding the distribution of funds preempts the prerogative of States. NASCSP urges the committee to discourage the incorporation of authorization language in the appropriations act.

NASCSP is the national association that represents State administrators of the Community Services Block Grant (CSBG), and State directors of the Department of Energy's Low-Income Weatherization Assistance Program.

BACKGROUND

The States believe the Community Services Block Grant (CSBG) is a unique block grant that has successfully devolved decision making to the local level. Federally funded with oversight at the State level, the CSBG has maintained a local network of nearly 1,100 agencies which coordinate nearly $9.7 billion in Federal, State, local, and private resources each year. Operating in 99 percent of counties in the Nation and serving nearly 15.2 million low-income persons, local agencies, known as Community Action Agencies (CAAs), provide services based on the characteristics of poverty in their communities. For one town, this might mean providing job placement and retention services; for another, developing affordable housing; in rural areas it might mean providing access to health services or developing a rural transportation system.

Since its inception, the CSBG has shown how partnerships between States and local agencies benefit citizens in each State. We believe it should be looked to as a model of how the Federal Government can best promote self-sufficiency for low-income persons in a flexible, decentralized, non-bureaucratic and accountable way.

Long before the creation of the Temporary Assistance for Needy Families (TANF) block grant, the CSBG was setting the standard for private-public partnerships that

work to the betterment of local communities and low-income residents. Family oriented, while promoting economic development and individual self-sufficiency, the CSBG relies on an existing and experienced community-based service delivery system of CAAs and other non-profit organizations to produce results for its clients.

MAJOR CHARACTERISTICS OF THE COMMUNITY SERVICES NETWORK

Emergency Response.—CAAs are utilized by Federal and State emergency personnel as a frontline resource to deal with emergency situations such as floods, hurricanes and economic downturns. They are also relied on by citizens in their community to deal with individual family hardships, such as house fires or other emergencies.

In fact, during and after Hurricane Katrina and Rita the State CSBG offices and local CAAs quickly mobilized to provide immediate and long-term assistance to over 355,000 evacuees. This immediate assistance included, but was not limited to, transportation, food, medical check-ups, housing, utility deposits, job placement, and clothing. State CSBG offices and CAAs across the country coordinated their relief efforts with other agencies providing disaster relief assistance such as FEMA, Red Cross, and other faith-based and community-based organizations.

State CSBG offices through their local network of CAAs continue to provide the long-term assistance evacuees will need as they relocate and re-establish themselves through self-sufficiency and family development programs. These programs offer comprehensive approaches to selecting and offering supportive services that promote, empower and nurture the individuals and families seeking economic self-sufficiency. At a minimum, these approaches include:

—A comprehensive assessment of the issues facing the family or family members and of the resources the family brings to address these issues;
—A written plan for becoming more financially independent and self-supporting;
—A comprehensive mix of services that are selected to help the participant implement the plan;
—Professional staff members who are flexible and can establish trusting, long-term relationships with program participants; and
—A formal methodology used to track and evaluate progress as well as to adjust the plan as needed.

Additional information on the CSBG Network's Hurricane Katrina relief efforts may be found in the attached issue brief.

Accountable.—The Federal Office of Community Services, State CSBG offices and CAAs have worked closely to develop a results-oriented management and accountability (ROMA) system. Through this system, individual agencies determine local priorities within six common national goals for CSBG and report on the outcomes that they achieved in their communities.

Leveraging Capacity.—For every CSBG dollar they receive, CAAs leverage $4.87 in non-federal resources (State, local, and private) to coordinate efforts that improve the self-sufficiency of low-income persons and lead to the development of thriving communities.

Volunteer Mobilization.—CAAs mobilize volunteers in large numbers. In fiscal year 2004, the most recent year for which data are available, the CAAs elicited more than 44 million hours of volunteer efforts, the equivalent of almost 21,182 full-time employees. Using just the minimum wage, these volunteer hours are valued at nearly $227 million.

Locally Directed.—Tri-partite boards of directors guide CAAs. These boards consist of one-third elected officials, one-third low-income persons and one-third representatives from the private sector. The boards are responsible for establishing policy and approving business plans of the local agencies. Since these boards represent a cross-section of the local community, they guarantee that CAAs will be responsive to the needs of their community.

Adaptability.—CAAs provide a flexible local presence that governors have mobilized to deal with emerging poverty issues.

The statutory goal of the CSBG is to ameliorate the effects of poverty while at the same time working within the community to eliminate the causes of poverty. The primary goal of every CAA is self-sufficiency for its clients. Helping families become self-sufficient is a long-term process that requires multiple resources. This is why the partnership of Federal, State, local, and private enterprise has been so vital to the successes of the CAAs.

WHO DOES THE CSBG SERVE?

National data compiled by NASCSP show that the CSBG serves a broad segment of low-income persons, particularly those who are not being reached by other pro-

grams and are not being served by welfare programs. Based on the most recently reported data, from fiscal year 2004:

—More than 2.7 million customer families have incomes at or below the poverty level; 1.1 million customer families have incomes at or below 50 percent of the poverty guidelines. In 2004, the poverty level for a family of three was $15,670.
—58 percent of adults have a high school diploma or equivalency certificate.
—44 percent of all customer families are "working poor" and have wages or unemployment benefits as income.
—23 percent depend on pensions and Social Security and are therefore poor, former workers.
—Almost 430,000 families are TANF participants, 22 percent of the average monthly TANF caseload.
—Nearly 60 percent of families assisted have children under 18 years of age.

WHAT DO LOCAL CSBG AGENCIES DO?

Since Community Action Agencies operate in rural areas as well as in urban areas, it is difficult to describe a typical Community Action Agency. However, one thing that is common to all is the goal of self-sufficiency for all of their clients. Reaching this goal may mean providing day care for a struggling single mother as she completes her General Equivalency Diploma (GED) certificate, moves through a community college course and finally is on her own supporting her family without Federal assistance. It may mean assisting a recovering substance abuser as he seeks employment. Many of the Community Action Agencies' clients are persons who are experiencing a one-time emergency. Others have lives of chaos brought about by many overlapping forces—a divorce, sudden death of a wage earner, illness, lack of a high school education, closing of a local factory or the loss of family farms.

CAAs provide access to a variety of opportunities for their clients. Although they are not identical, most will provide some if not all of the services listed below:

—a variety of crisis and emergency safety net services;
—employment and training programs;
—transportation and child care for low-income workers;
—individual development accounts;
—micro business development help for low-income entrepreneurs;
—local community and economic development projects;
—housing and weatherization services;
—Head Start;
—energy assistance programs;
—nutrition programs;
—family development programs; and
—senior services.

CSBG funds many of these services directly. Even more importantly, CSBG is the core funding which holds together a local delivery system able to respond effectively and efficiently, without a lot of red tape, to the needs of individual low-income households as well as to broader community needs. Without the CSBG, local agencies would not have the capacity to work in their communities developing local funding, private donations and volunteer services and running programs of far greater size and value than the actual CSBG dollars they receive.

CAAs manage a host of other Federal, State and local programs which makes it possible to provide a one-stop location for persons whose problems are usually multifaceted. Over half (52 percent) of the CAAs manage the Head Start program in their community. Using their unique position in the community, CAAs recruit additional volunteers, bring in local school department personnel, tap into religious groups for additional help, coordinate child care and bring needed health care services to Head Start centers. In many States they also manage the Low Income Home Energy Assistance Program (LIHEAP), raising additional funds from utilities for this vital program. CAAs may also administer the Weatherization Assistance Program and are able to mobilize funds for additional work on residences not directly related to energy savings that, for example, may keep a low-income elderly couple in their home. CAAs also coordinate the Weatherization Assistance Program with the Community Development Block Grant program to stretch Federal dollars and provide a greater return for tax dollars invested. They also administer the Women, Infants and Children (WIC) nutrition program as well as job training programs, substance abuse programs, transportation programs, domestic violence and homeless shelters, as well as food pantries.

EXAMPLES OF CSBG AT WORK

Since 1994, CSBG has implemented Results-Oriented Management and Accountability practices whereby the effectiveness of programs is captured through the use of goals and outcomes measures. Below you will find the network's first nationally aggregated outcomes achieved by individuals, families and communities as a result of their participation in innovative CSBG programs during fiscal year 2004:

—103,057 participants gained employment with the help of community action (49 States reporting);
—13,313 participants obtained "living wage" employment with benefits (35 States reporting);
—88,187 low-income participants obtained safe and affordable housing in support of employment stability (43 States reporting);
—510,322 low-income households achieved an increase in non-employment financial assets, including tax credits, child support payments, and utility savings, as a result of community action ($133.5 million in aggregated savings);
—5,645 families achieved home ownership as a result of community action assistance (41 States reporting);
—56,283 low-income people obtained pre-employment skills and received training program certificates or diplomas (47 States reporting);
—30,776 low-income people completed Adult Basic Education or GED coursework and received certificates or diplomas (40 States reporting);
—9,647 low-income people completed post-secondary education and obtained a certificate or diploma (41 States reporting); and
—2,284,577 new community opportunities and resources were created for low-income families as a result of community action work or advocacy, including "living wage" jobs, affordable and expanded public and private transportation, medical care, child care and development, new community centers, youth programs, increased business opportunity, food, and retail shopping in low-income neighborhoods (46 States reporting).

All the above considered, NASCSP urges this committee to fund the CSBG grant to the States at $650 million.

PREPARED STATEMENT OF THE NATIONAL CONSUMER LAW CENTER

The National Consumer Law Center (NCLC),[1] on behalf of our low-income clients,[2] respectfully submits this testimony regarding the appropriation of funds for the Low Income Home Energy Assistance Program (LIHEAP)[3] for fiscal year 2007. NCLC and our clients are strong supporters of LIHEAP, the primary safety net between low-income consumers and the disconnection of vital utility service. The high energy prices that squeeze the budgets of low-income households to the breaking point show no sign of abating. The recent National Energy Assistance Directors' Association (NEADA) national study on LIHEAP recipients documents the tremendous value of LIHEAP to low-income families as well as the severe sacrifices made by the poor to pay their home energy bills.[4] Low-income families and fixed-income elderly clients continue to fall further behind as energy prices have reached a new, higher baseline. LIHEAP is essential for their safety and well being. We thank the subcommittee for its strong support of the LIHEAP program in the fiscal year 2006 appropriations process and, in light of the forecasted continued high energy prices, urge the subcommittee to consider fully appropriating LIHEAP at $5.1 billion in regular LIHEAP funds for fiscal year 2007, the amount authorized under the Energy Policy Act of 2005, with advance appropriations of the same amount for fiscal year 2008.

Home Energy Prices Are At An All-Time High.—Residential energy prices were expected to continue to rise this year, but the disruption in the Gulf fuel refineries by the hurricanes sent them skyrocketing. Consequently, paying home energy bills has been all the more difficult for fixed income seniors and low-income households and has made LIHEAP all the more important for these vulnerable families. The

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[1] The National Consumer Law Center (NCLC) is a nonprofit organization that represents the interests of low-income consumers on a broad range of issues, including access to adequate and affordable supplies of utility service for home heating and cooling. This testimony was prepared by Olivia Wein, staff attorney in NCLC's Washington, DC office.

[2] The Appalachian People's Action Coalition (Ohio); Texas Legal Services Center; Action, Inc. (Gloucester, MA); Action for Boston Community Development, Inc.

[3] 42 U.S.C. § 8621 et seq.

[4] National Energy Assistance Directors Association, National Energy Assistance Survey (April 2004) (NEADA survey) available at www.neada.org.

Center on Budget and Policy Priorities has acknowledged that this year marks the "largest 1-year jump in home heating prices in three decades."[5] According to Guy Caruso, Administrator of the Energy Information Administration at the U.S. Department of Energy, "several factors are driving up winter prices and expenditures: first, international factors such as low spare crude oil capacity and political tensions contribute to uncertainty and low supply growth for crude oil and high crude prices; second, recent hurricanes and associated disruptions exacerbate already tight markets in oil, petroleum products, and natural gas; and, finally, winter weather affects consumption and consequently household expenditures."[6] The summer heat is also dangerous, especially for the elderly, the very young and those with chronic diseases. Unfortunately, the vast majority of newer electric generation plants rely on natural gas, thus tying electricity prices to the volatile natural gas prices. Taking all of these factors into account, it is obvious how critical LIHEAP's heating and cooling assistance is to the livelihood of so many families. The mounting increases in essential residential energy prices as illustrated in the chart below are putting more and more families' health and safety at risk.

More Households Than Ever Cannot Keep Up With Costs Of Home Energy.—Although the costs of home energy have been a burden to most Americans, those with low incomes have been hurt the most. The salary for low-income Americans has stayed relatively flat while the cost of living has gone up, resulting in even more challenging struggles just to make ends meet for many families. According to Dr. Meg Power of Economic Opportunity Studies, families below 150 percent of the Federal poverty guideline spend on average about $1,470 on energy costs, about 19 percent of their total yearly income. In 2005, however, low income families were expected to pay more than $1,650.[7] Those prices will only go up for 2006. Having their heat switched off is a real possibility for numerous low-income households, and although there are winter utility shut-off moratoria in place for many States, not every home is protected against energy shut-offs in the middle of winter. As we approach the lifting of winter shut-off moratoria, we expect to see a wave of disconnections as households are unable to afford the cost of the energy bills. In the summer, the inability to keep the home cool can be lethal, especially to seniors. According to the CDC, in 2001 300 deaths were caused by excessive heat exposure and seniors and young children are particularly vulnerable to heat stress.[8] The CDC also notes that air-conditioning is the number one protective factor against heat-related illness and death.[9]

Iowa.—Despite milder winter temperatures this winter, the sharp rise in natural gas prices has set back a record number of low-income households in Iowa. The number of low-income households with past due energy accounts as of January 2006 is 14.7 percent higher than the same time last year and 162 percent higher than the number in January 1999. The total amount of arrearages of LIHEAP households has also grown sharply due to the increase in prices. By January 2006, the total amount of LIHEAP household arrearages had increased 32 percent from the same period in 2005 and 169 percent compared to the same period in 1999. The total number of LIHEAP households increased 8 percent from this same period last year.[10]

Ohio.—In Ohio, the number of households entering into the State's low-income energy affordability program, the Percentage of Income Payment Program (PIPP), increased 23 percent from January 2005 to January 2006. The increase is even more dramatic at 84 percent, when comparing PIPP enrollment from January 2002 to January 2006. The total dollar arrearage amounts for PIPP customers also increased 27 percent from January 2005 to January 2006. Likewise, the total PIPP arrearages have increased dramatically, 84 percent, from January 2002 to January 2006. Ohio's LIHEAP program expects to provide heating assistance to almost 5 percent more households in fiscal year 2006 than in fiscal year 2005 (and almost 30

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[5] Center on Budget and Policy Priorities. "Steep Spike in Energy Costs Increases Low-Income Households' Need For Help Paying Heating Bills This Winter" (Oct. 6, 2005).

[6] Statement of Guy Caruso, Administrator for the Energy Information Administration, U.S. Department of Energy before the Committee on Energy and Natural Resources, United States Senate. Full Committee Hearing—Winter Fuels Outlook (Oct. 18, 2005).

[7] Meg Power, PhD. Economic Opportunity Studies. "Energy Bills of Low-Income Consumers in Fiscal Year 2005, The Resources Available to Help Them Pay, and the Impact on Their Household Budgets" (Nov. 23, 2004).

[8] CDC, "Extreme Heat: A Prevention Guide to Promote Your Personal Health and Safety" available at www.bt.cdc.gov/disasters/extremeheat/heat__guide.asp.

[9] Id.

[10] National Energy Assistance Directors, "Est. Total Households Receiving LIHEAP Heating Assistance by State—Projected Applications for Fiscal Year 2006" (2/13/06).

percent more households when compared to Ohio households that received heating assistance in fiscal year 2002).[11]

Pennsylvania.—Utilities in Pennsylvania that are regulated by the Pennsylvania Public Utility Commission (PA PUC) have established universal service programs that assist utility customers in paying bills and reducing energy usage. Even with these programs, electric and natural gas utility customers find it difficult to keep pace with their energy burdens. The PA PUC estimates that approximately 21,000 households entered the current heating season without heat-related utility service—this number includes about 4,000 households who are heating with potentially unsafe heating sources such as kerosene space heaters. This is an increase of 68 percent when compared to the average number entering the heating season without heat for the years 2000–2003. An additional 17,500 residences where service was previously terminated are now vacant.[12] In 2005, the number of terminations increased 52 percent compared with terminations in 2004.[13] As of January 2006, 17.48 percent of residential electric customers and 18.19 percent of natural gas customers are overdue on their energy bills. As of February 2006, Pennsylvania projected serving 354,065 LIHEAP applicants in fiscal year 2005, an 8.2 percent increase over the prior year.[14]

LIHEAP Helps These Vulnerable Households.—Growing utility arrearages for low-income households will only place these fragile households on a downward spiral towards disconnections. Adequate LIHEAP assistance can help families facing terminations, but, even more importantly, adequate LIHEAP appropriations can help struggling families maintain vital energy services and protect the health and safety of vulnerable seniors, families with young children or disabled family members. The recent NEADA national energy assistance survey found that 48 percent of LIHEAP recipients would have had their electricity or home heating fuel discontinued if LIHEAP had not been available.[15]

The Need For LIHEAP Is Greater Than Ever.—The continued sharp rise in residential energy prices is expected for the near future. The data from Iowa, Ohio and Pennsylvania, which are amongst the few States that collect residential utility customer payment data, show that even in a milder than normal winter, the prices have risen to such a degree that an increasing number of low-income households is falling behind. This year's dramatic rise in residential energy prices has yielded the greatest number of LIHEAP applications in 12 years.[16] Last year, the number of eligible recipients for LIHEAP climbed to 32 million; however, only around 5 million were able to benefit from it.

The Consequences Of Unaffordable Energy Bills Are Dire.—When people are unable to afford paying their home energy bills, many dangerous and unhealthy actions are often taken. Common practices include resorting to alternative heating sources, such as space heaters, ovens and burners, all of which are huge fire hazards; numerous deaths due to fires started by space heaters have already occurred this year and are a recurring problem every year. According to the U.S. Consumer Product Safety Commission, about 25,000 fires in homes are caused by space heaters and 300 people are killed because of them every year in the United States.[17] Other dangerous practices include illegal gas hookups that create dangerous gas leaks, keeping the thermostat at unhealthy and sometimes hypothermic temperatures (and hyperthermic temperatures in the summer). Those who cannot afford their winter heating bill often face dire choices such as sacrificing food, medical care or prescription medicine.[18] In the summer, the inability to afford cooling bills can result in heat-related deaths and illness. The loss of essential utility services can be devastating, especially for poor families that can find themselves facing the pros-

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[11] Based on date from the National Energy Assistance Directors, "Est. Total Households Receiving LIHEAP Heating Assistance by State—Projected Applications for Fiscal Year 2006 (2/13/06)" and "Estimated Total Households Receiving LIHEAP Heating Assistance by State Actuals in 2002, 2003; Projected in 2004." Available at www.neada.org.

[12] http://www.puc.state.pa.us/general/press__releases/press__releases.aspx?ShowPR=1435.

[13] http://www.puc.state.pa.us/general/pdf/Terminations__Table__Jan-Dec04-05.pdf

[14] http://www.neada.org/news/news060213__liheap06projections.pdf

[15] NEADA Survey, Table 47.

[16] http://www.neada.org/news/news060213__liheap06projections.pdf.

[17] U.S. Department of Energy: A Consumer's Guide to Energy Efficiency and Renewable Energy. http://www.eere.energy.gov/consumer/your__home/space__heating__cooling/index.cfm/mytopic=12600.

[18] NEADA Survey, Table 39. To pay their energy bills, 22 percent of LIHEAP recipients went without food, 38 percent went without medical or dental care, 30 percent did not fill or took less than the full dose of a prescribed medicine.

pects of hypothermia in the winter, hyperthermia in the summer,[19] eviction, property damage from frozen pipes, the use of dangerous alternative sources of heat,[20] and the potential threat of the intervention of child welfare agencies.[21] Studies have also demonstrated the clear links between homelessness and utility disconnections, as well as the connections between unaffordable utility service and the disruption to families and children's education. LIHEAP works to bring fuel costs within a manageable range for low-income households. There are other societal benefits to a strong LIHEAP. A recent study documents an association between receipt of LIHEAP assistance and a reduced incidence of undernutrition in young children.[22]

People are putting themselves at risk when they do not have sufficient funds to pay their home energy bills, but LIHEAP can and does come to their aid and does greatly alleviate some of the hardship caused by high energy bills. With the assistance of LIHEAP, households will not have to make such unconscionable, dangerous sacrifices.

The Need for Advance Appropriations is Critical.—The timing of the release of the LIHEAP block grant to the States is critical for the effective and efficient operation of the State programs. The normal appropriations process leaves very little time between enactment of the Labor-HHS-Education spending bill and the start of most States' heating programs. An advance appropriation is essential for States to determine income guidelines and benefit levels well ahead of time and for properly planning the components of their program year (e.g., amounts set aside for heating, cooling and emergency assistance, weatherization, self sufficiency and leveraging activities). Without advance appropriations, delayed passage of the spending bill can force States to open their winter heating program without knowledge of their final grant amount. Advance appropriations shield States from disruption of the start-up of their winter heating programs if there is a delay in the passage of the Labor-HHS-Education spending bill.

LIHEAP Works.—LIHEAP is a targeted block grant that assists vulnerable low-income households with the costs of home energy. According to the U.S. Department of Health and Human Services, one-third of households receiving LIHEAP heating and cooling assistance had an elderly member; over 30 percent of households receiving heating and cooling assistance had a member with a disability; and almost one third of households receiving heating assistance and around a fifth of households receiving cooling assistance had young children. In fiscal year 2001, LIHEAP recipient households had a mean individual energy burden almost five times the energy burden for non-low income households.[23] A While there are broad Federal guidelines for LIHEAP, States have the flexibility to tailor their programs to best meet their needs. Administrative costs are minimal—capped at 10 percent. This ensures that the vast majority of LIHEAP dollars are directed to energy assistance for low-income families.

The National Association of Regulatory Utility Commissioners (NARUC), the National Energy Assistance Directors Association and the National Fuel Funds Network also support fully funding the regular block grant LIHEAP program at $5.1 billion.

Conclusion.—In light of the continued projected increase in residential energy costs and LIHEAP's continued demonstrated success in helping low-income families maintain access to vital energy service, we urge the subcommittee to appropriate $5.1 billion for the regular LIHEAP program in fiscal year 2007 as well as advance appropriations for fiscal year 2008 of $5.1 billion for the regular program. Thank you for consideration of our testimony.

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[19] From 2000 to 2003, approximately 50 percent-68 percent of heat-related deaths were 60 years old or older. Office of Climate, Water and Weather Services, Heat Related Fatalities by Age and Gender, reports for 2000—2003.

[20] In 1998 there were over 49,000 heating-equipment related home fires resulting in 388 deaths and 1,445 injuries and $515 million in property damage. National Fire Protection Association Fact Sheets on Home Heating, in United States Home Heating Fire Patterns and Trends, John H. Hall, Jr., NFPA, June 2001.

[21] Robert B. Swift, Rising Costs for Home Heating Fuel Could Spawn More Problems, Sunbury (PA) Item, Jan. 29, 2000.

[22] Pediatric Academic Societies, Publication #921, Platform Presentation, Epidemiology Session, May 6, 2003, Seattle, WA: Children's Sentinel Nutrition Assessment Program: Heat or Eat: Low Income Home Energy Assistance Program and Nutritional Risk Among Children < 3.

[23] U.S. Department of Health and Human Services, Administration for Children and Families, Office of Community Services, Division of Family Assistance, LIHEAP Home Energy Notebook for Fiscal Year 2001 (February 2003), Table A–2b, p. 49.

PREPARED STATEMENT OF THE NATIONAL KIDNEY FOUNDATION

The National Kidney Foundation (NKF), a voluntary health organization whose membership includes patients and families; organ transplant recipients; families who have donated the organs of loved ones for transplantation and living organ donors; and health care professionals, is pleased to submit public witness testimony for the written record in support of fiscal year 2007 Appropriations.

We are very appreciative of the $1,800,000 in funding that Congress provided in fiscal year 2006 to establish a Chronic Kidney Disease (CKD) program within the Centers for Disease Control and Prevention (CDC). As the subcommittee drafts the fiscal year 2007 Labor, Health and Human Services, and Education Appropriations Bill, we respectfully request your continued support for funding to expand these activities, as outlined below. Unfortunately, the administration did not request continued funding for this program in its 2007 Budget Request.

IMPACT OF CHRONIC KIDNEY DISEASE

The implications of kidney disease for the public are considerable, yet the average American is relatively unaware of its consequences. Twenty million Americans have CKD, and another 20 million are at risk of developing the disease, but most people with kidney disease do not know they have it and will not be diagnosed until it has threatened their health and even their lives. Individuals with diabetes or hypertension are especially vulnerable.

Kidney disease is the 9th leading cause of death in the United States, and death by cardiovascular disease is 10 to 30 times higher in kidney dialysis patients than in the general population. Kidney disease is associated with 25 percent of the Medicare budget and 7 percent of the Medicare population has a diagnosis of kidney disease. Further, the number of individuals with end stage renal disease (ESRD), irreversible kidney failure requiring either dialysis or a transplant to remain alive, is expected to increase from 382,000 patients in 2000 to 712,000 by 2015. Effective treatments are available to reduce morbidity and mortality resulting from kidney disease and its complications and to retard progression to kidney failure. However, CKD is not being detected sufficiently early to initiate treatment regimens and reduce death and disability. NKF believes a public health approach would contribute toward early detection and treatment, thereby reducing hardship and saving money and lives.

2006 CDC ACTIVITIES

NKF is working closely with CDC to implement this program and we are very pleased with the progress to date. CDC intends to use the current-year appropriation to identify and coordinate sources for CKD data; propose solutions to fill data deficiencies; undertake a surveillance system feasibility study; fund pilot projects in selected States; and, organize an expert consensus conference to lay the groundwork for a Public Health Kidney Disease Strategic Plan. Earlier this year, CDC requested proposals to support the development of a comprehensive CKD surveillance system. The agency expects to award two grants in 2006 designed to identify sources of CKD data, as well as gaps and deficiencies in existing data. The program will also propose solutions to remedy deficiencies, including the execution of a feasibility study and pilot test for a surveillance system. Additional activities in 2006 will include studies of the economic benefit of CKD intervention.

FISCAL YEAR 2007 REQUEST

A restoration of funding to the 2006 level would enable CDC to continue planning for capacity and infrastructure for a kidney disease epidemiology, research and health outcomes program and to institute a CKD surveillance system. We are hopeful for a funding increase over fiscal year 2006, which would enable the agency to expand the number and scope of grants to support State-based community demonstration projects for CKD detection and treatment, a core component of this CKD initiative. We envision this would include tracking the progression of CKD in patients who have been diagnosed, as well as identify the onset of kidney disease among individuals who are members of high risk groups.

We thank you for your past support of this initiative and respectfully request your continued support, to enable CDC and the public health community to move forward to address the growing concern of Chronic Kidney Disease.

PREPARED STATEMENT OF THE NATIONAL LEAGUE FOR NURSING

The National League for Nursing (NLN)—representing more than 1,100 nursing schools and health care agencies, some 17,000 individual members comprised of nurses, educators, administrators, public members, and 18 constituent leagues—appreciates the subcommittee's past support for nursing education and your continued recognition of the important role nurses play in the delivery of health care services.

We, however, are concerned. Unless additional resources are expended, the advancements made by Congress to help alleviate the nursing shortage will be impeded owing to the currently proposed fiscal year 2007 appropriations level. The NLN advocates your continued support for Title VIII—Nursing Workforce Development Programs (Public Health Services Act), housed in the Health Resources and Services Administration (HRSA) with the congressionally prescribed mission of ensuring a sufficient supply of nurses. We urge you to fund the Title VIII programs at a minimum level of $175 million for fiscal year 2007. Placing this minimal funding request in perspective, note that during the last serious nursing shortage in 1974, Congress appropriated $153 million for nurse education programs. In today's dollars that appropriation would equate to approximately $592 million, nearly four times the amount the Federal Government is spending on nurse education now.

Today's nursing shortage is very real and very different from any experienced in the past. The existing shortage is evidenced by an aging workforce and too few people entering the profession. A critical factor exacerbating the national nurse-workforce deficiency is the declining number of qualified nurses available to teach future generations of registered nurses. The NLN's Faculty Survey conducted in 2002 concludes that not enough qualified nurse educators exist to teach the number of nurses necessary to ameliorate the nursing shortage.

The NLN Survey found three trends influencing the future of nursing education over the next decade:

The aging of the nurse faculty population

An average of 1.3 full-time faculty members per program left their positions in nursing education in 2002. About half the survey respondents had at least one unfilled budgeted full-time faculty position and some had as many as 15 such positions. 36.5 percent of faculty who left their positions in the preceding year did so because of retirement; 8.6 percent of faculty were 61 years of age or older; and 75 percent of the current faculty population is expected to retire by 2019.

Approximately 1,800 full-time faculty members leave their positions each year. About 10,000 master's level nurses graduate per year, 15 percent of whom would have to enter teaching in order to maintain today's production level for generating the Nation's nurse workforce. Since this is highly unlikely, the gap between unfilled positions and the candidate pool is widening significantly.

The increasing number of part-time faculty

The number of part-time faculty has increased notably since 1996—nearly 17 percent in baccalaureate programs and 14 percent in associate degree programs. Part-time faculty now provides approximately 23 percent of the estimated number of faculty FTEs.

Part-time employees often are not an integral part of the design, implementation, and evaluation of the overall nursing education program. Many may hold other positions that often limit their availability to students. Further, many part-time faculty have not been prepared for the faculty role.

The large number of nursing faculty who are not prepared at the doctoral level

Approximately half the full-time faculties in baccalaureate and higher-degree programs hold a doctoral degree. In associate degree programs, doctorally-prepared faculty account for only 6.6 percent of the total faculty and the number is slightly more than 5 percent in diploma programs. Only 350 to 400 nursing students receive doctoral degrees each year and the pool of doctorally-prepared candidates for full-time nursing professorships is very limited.

Educators without doctoral degrees may lack credibility within a university setting and have limited opportunities to assume leadership positions. Institutions with low numbers of doctorally-prepared educators may be less likely to obtain funds to support research or educational innovations. As important as educational incentives are for future practicing nurses, the scholarships for doctoral students who will instruct the next generation of nurses are even more critical.

Since less than an adequate number of nurse educators currently teach in the education pipeline, the situation appears to be growing acute and is not expected to improve in the near future absent adequate intervention. In a survey of the 2004–2005 academic year conducted by the NLN, an estimated 147,000 qualified ap-

plications were turned away from nursing programs at all degree levels owing in large part to the lack of faculty necessary to teach this number of additional students. This number represents a 17.6 percent increase from the 2003–2004 academic year. With an increasing application pool, a key priority in tackling the nurse shortage has to be scaling up the capacity to accept qualified applicants. Today's undersized supply of appropriately prepared nurses and nurse faculty does not bode well for meeting the needs of a diverse, aging population.

Congress made an important step in passing the Nurse Reinvestment Act in 2002. The new monies used to fund loans and scholarships are appreciated. Yet, it has become abundantly clear that significantly more funding is required to even minimally meet the HRSA charge to support nursing students and schools of nursing so as to meet the existing and rising national needs for nurses. In fiscal year 2005, HRSA was forced to turn away 82 percent of the applicants for the Nurse Education Loan Repayment Program and more than 98 percent of the applicants for the Nursing Scholarship Program due to lack of adequate funding.

Please do not allow the Nation to lose ground in the effort to remedy the nursing shortage. Fund Title VIII—Nursing Workforce Development Programs at a level commensurate with the severity of the health care crisis facing the Nation today. Your support will help ensure that nurses exist in the future who are prepared and qualified to take care of you, your family, and all those in this country who will need our care.

PREPARED STATEMENT OF THE ONCOLOGY NURSING SOCIETY

The Oncology Nursing Society (ONS) appreciates the opportunity to submit written comments for the record regarding fiscal year 2007 funding for cancer and nursing related programs. ONS, the largest professional oncology group in the United States composed of more than 33,000 nurses and other health professionals, exists to promote excellence in oncology nursing and the provision of quality care to those individuals affected by cancer. As part of its mission, the Society honors and maintains nursing's historical and essential commitment to advocacy for the public good.

This year more than 1.4 million Americans will be diagnosed with cancer and more than 565,000 will lose their battle with this terrible disease. Despite these grim statistics, significant gains in the War Against Cancer have been made through our Nation's investment in cancer research and its application. Research holds the key to improved cancer prevention, early detection, diagnosis, and treatment, but such breakthroughs are meaningless unless we can deliver them to all Americans in need. Recent studies have reported 126,000 registered nurse vacancies in hospitals and 13,900 registered nurse vacancies in nursing homes. Moreover, a recent survey of ONS members found that the nursing shortage is having an adverse impact in oncology physician offices and hospital outpatient departments. Some respondents indicated that when a nurse leaves their practice that they are unable to hire a replacement due to the shortage—leaving them short-staffed and posing scheduling challenges for the practice and the patients. These vacancies in all care settings create significant barriers to ensuring access to quality care.

To ensure that all people with cancer have access to the comprehensive, quality care they need and deserve, ONS advocates on-going and significant Federal funding for cancer research and application, as well as funding for programs that help ensure an adequate oncology nursing workforce to care for people with cancer. The Society stands ready to work with policymakers at the local, State, and Federal levels to advance policies and programs that will reduce and prevent suffering from cancer and sustain and strengthen the Nation's nursing workforce.

SECURING AND MAINTAINING AN ADEQUATE ONCOLOGY NURSING WORKFORCE

Oncology nurses are on the front lines in the provision of quality cancer care for individuals with cancer—administering chemotherapy, managing patient therapies and side-effects, working with insurance companies to ensure that patients receive the appropriate treatment, providing counseling to patients and family members, and engaging in myriad other activities on behalf of people with cancer and their families. Cancer is a complex, multifaceted chronic disease, and people with cancer require specialty-nursing interventions at every step of the cancer experience. People with cancer are best served by nurses specialized in oncology care, who are certified in that specialty. Overall, age is the number one risk factor for developing cancer. Approximately 77 percent of all cancers are diagnosed at age 55 and older. Currently, Medicare beneficiaries account for more than 50 percent of all cancer diagnoses and 64 percent of cancer deaths. Over the next 10 to 15 years the number of Medicare beneficiaries with cancer is estimated to double while, according to U.S.

Department of Labor estimates, more than 1.1 million registered nursing vacancies will need to be filled by 2012 to meet growing patient demand and replace retiring nurses.

As the overall number of nurses will drop precipitously in the coming years, we likely will experience a commensurate decrease in number of nurses trained in the specialty of oncology. With an increasing number of people with cancer needing high quality health care, coupled with an inadequate nursing workforce, our Nation could quickly face a cancer care crisis of serious proportion with limited access to quality cancer care, particularly in traditionally underserved areas. A study in the New England Journal of Medicine found that nursing shortages in hospitals are associated with a higher risk of complications—such as urinary tract infections and pneumonia, longer hospital stays, and even patient death. Without an adequate supply of nurses, there will not be enough qualified oncology nurses to provide the quality cancer care to a growing population of people in need and patient health and well-being could suffer.

Further, of additional concern is that our Nation also will face a shortage of nurses available and able to conduct cancer research and clinical trials. With a shortage of cancer research nurses, progress against cancer will take longer because of scarce human resources coupled with the reality that some practices and cancer centers resources could be funneled away from cancer research to pay for the hiring and retention of oncology nurses to provide direct patient care. Without a sufficient supply of trained, educated, and experienced oncology nurses, our Nation may falter in its delivery and application of the benefits from our Federal investment in research.

ONS has joined with others in the nursing community in advocating $175 million as the fiscal year 2007 funding level necessary to support implementation of the Nurse Reinvestment Act and the range of nursing workforce programs housed at the U.S. Health Resources and Services Administration (HRSA). Enacted in 2002, the Nurse Reinvestment Act included new and expanded initiatives, including loan forgiveness, scholarships, career ladder opportunities, and public service announcements to advance nursing as a career. Despite the enactment of this critical measure, HRSA fails to have the resources necessary to meet the current and growing demands for our Nation's nursing workforce. For example, in fiscal year 2005, HRSA was forced to turn away 82 percent of the applicants for the Nurse Education Loan Repayment Program and over 98 percent of the applicants for the Nursing Scholarship Program due to lack of adequate funding.

While a number of years ago one of the biggest factors associated with the shortage was a lack of interested and qualified applicants, due to the efforts of the nursing community and other interested stakeholders, the number of applicants is growing. As such, now one of the greatest factors contributing to the shortage is that nursing programs are turning away qualified applicants to entry-level baccalaureate programs due to a shortage of nursing faculty. According to the American Association of Colleges of Nursing (AACN), at least 32,617 of such qualified applicants were turned away in 2004 alone. Many of these qualified students are being placed on waiting lists that may be as long as 2 years or more. The National League for Nursing (NLN) released a preliminary report in December 2005 that showed that due to faculty shortages, in total schools of nursing were forced to reject more that 147,000 qualified applications for 2005, an 18 percent increase over 2004 figures. The number of full-time nursing faculty required to "fill the nursing gap" is approximately 40,000 and currently there are less than 20,000 full-time nursing faculty in the system. The nurse faculty shortage is only expected to worsen with time as faculty age continues to climb, averaging 52 years in 2004. Significant numbers of faculty are expected to retire in the coming years with insufficient numbers of candidates in the pipeline to take their places. If funded sufficiently, the components and programs of the Nurse Reinvestment Act will help address the multiple factors contributing to the nursing shortage.

ONS strongly urges Congress to provide HRSA with a minimum of $175 million in fiscal year 2007 to ensure that the agency has the resources necessary to fund a higher rate of nursing scholarships and loan repayment applications and support other essential endeavors to sustain and boost our Nation's nursing workforce. Nurses—along with patients, family members, hospitals, and others—have joined together in calling upon Congress to provide this essential level of funding. One Voice Against Cancer (OVAC), a collaboration of more than 45 national nonprofit organizations representing millions of Americans, also advocates $175 million for the Nurse Reinvestment Act in fiscal year 2007. ONS and its allies have serious concerns that without full funding, the Nurse Reinvestment Act will prove an empty promise and the current and expected nursing shortage will worsen, and people will not have access to the quality care they need and deserve.

BOOST OUR NATION'S INVESTMENT IN CANCER PREVENTION, EARLY DETECTION, AND AWARENESS

Approximately two-thirds of cancer cases are preventable through lifestyle and behavioral factors and improved practice of cancer screening. Although the potential for reducing the human, economic, and social costs of cancer by focusing on prevention and early detection efforts remains great, our Nation does not invest sufficiently in these strategies. While as a Nation we spend almost a trillion dollars a year on our health care system, we only allocate approximately 1 percent of that amount for population-based prevention efforts. By 2020, cancer and other chronic disease expenditures will reach $1 trillion or 80 percent of health care costs. The Nation must make significant and unprecedented Federal investments today to address the burden of cancer and other chronic diseases, and to reduce the demand on the healthcare system and diminish suffering in our Nation both for today and tomorrow.

As the Nation's leading prevention agency, the Centers for Disease Control and Prevention (CDC) plays an important role in translating and delivering at the community level what is learned from research. Therefore, ONS joins with our partners in the cancer community—including OVAC—in calling on Congress to provide additional resources for the CDC to support and expand much-needed and proven effective cancer prevention, early detection, and risk reduction efforts. Specifically, ONS advocates the appropriation of $427.5 million in fiscal year 2007 for the CDC's comprehensive cancer, ovarian cancer, breast and cervical cancer early detection, cancer registries, prostate cancer, colorectal cancer, and skin cancer programs. ONS also urges a funding increase for the CDC's physical activity, nutrition, and tobacco-control programs to help reduce risk factors for developing cancer and other chronic diseases. ONS advocates the following fiscal year 2007 funding levels:

—$250 million for the National Breast and Cervical Cancer Early Detection Program;
—$65 million for the National Cancer Registries Program;
—$25 million for the Colorectal Cancer Prevention and Control Initiative;
—$50 million for the Comprehensive Cancer Control Initiative;
—$20 million for the Prostate Cancer Control Initiative;
—$5 million for the National Skin Cancer Prevention Education Program;
—$7.5 million for the Ovarian Cancer Control Initiative;
—$5 million for the Geraldine Ferraro Blood Cancer Program;
—$145 million for the National Tobacco Control Program; and
—$70 million for the Nutrition, Physical Activity, and Obesity Program.

SUSTAIN AND SEIZE CANCER RESEARCH OPPORTUNITIES

Our Nation has benefited immensely from past Federal investment in biomedical research at the National Institutes of Health (NIH). ONS has joined with the broader health community in advocating $29.7 billion for NIH in fiscal year 2007. This will allow NIH to sustain and build on its research progress resulting from the recent doubling of its budget while avoiding the severe disruption to that progress that would result from a minimal increase. Cancer research is producing extraordinary breakthroughs—leading to new therapies that translate into longer survival and improved quality of life for cancer patients. We have seen extraordinary advances in cancer research resulting from our national investment that have produced effective prevention, early detection and treatment methods for many cancers. To that end, ONS calls upon Congress to allocate $5.034 billion to the National Cancer Institute (NCI) in fiscal year 2007 to continue our battle against cancer.

The National Institute of Nursing Research (NINR) supports basic and clinical research to establish a scientific basis for the care of individuals across the life span—from management of patients during illness and recovery to the reduction of risks for disease and disability and the promotion of healthy lifestyles. These efforts are crucial in translating scientific advances into cost-effective health care that does not compromise quality of care for patients. Additionally, NINR fosters collaborations with many other disciplines in areas of mutual interest such as long-term care for older people, the special needs of women across the life span, bioethical issues associated with genetic testing and counseling, and the impact of environmental influences on risk factors for chronic illnesses such as cancer. ONS joins with the nursing community in advocating an allocation of $150 million for NINR in fiscal year 2007.

CONCLUSION

ONS stands ready to work with policymakers to advance policies and support programs that will reduce and prevent suffering from cancer and sustain and strengthen our Nation's nursing workforce. Moreover, ONS maintains a strong commitment to working with Members of Congress, other nursing societies, patient organizations, and other stakeholders to ensure that the oncology nurses of today continue to practice tomorrow and that we recruit and retain new oncology nurses to meet the unfortunate growing demand that we will face in the coming years. Thank you for this opportunity to discuss the fiscal year 2007 funding levels necessary to ensure that our Nation has a sufficient nursing workforce to care for the patients of today and tomorrow and that our Nation continues to make gains in our fight against cancer.

PREPARED STATEMENT OF THE PANCREATIC CANCER ACTION NETWORK

On behalf of The Pancreatic Cancer Action Network (PanCAN), I thank you for this opportunity to present written testimony to the Labor, Health and Human Services, and Education subcommittee of the House Appropriations Committee.

PanCAN was founded in 1999 to focus national attention on the need to find the cure for pancreatic cancer. We provide public and professional education that embraces the urgent need for more research, effective treatments, prevention programs, and early detection methods. PanCAN is the first and only national patient based advocacy organization specifically focused on pancreatic cancer. We now have a full time staff of 30 individuals, and 90 "Team Hope" affiliates in communities across the country, comprised of thousands of volunteers who seek to increase awareness about this disease, raise funds, and voice their concern that there is a desperate need to find a cure for pancreatic cancer.

BACKGROUND ON PANCREATIC CANCER

Every 17 minutes, someone in the United States dies form pancreatic cancer. It is the 4th leading cause of cancer death in the Untied States. The facts on pancreatic cancer are striking:

—Over 33,730 Americans will be diagnosed with pancreatic cancer in 2006, and 32,300 will die from this disease.
—The 99 percent mortality rate is the highest of any cancer.
—There are no early detection methods.
—The average life expectancy after diagnosis with metastatic disease is just 3 to 6 months.

Yet, despite these statistics, pancreatic cancer receives the least amount of research funding from the Federal Government of all major cancers. Federal funding for pancreatic cancer research totaled roughly $66 million in fiscal year 2005, a mere 1 percent of the National Cancer Institute's (NCI's) $4.825 billion research budget. While good progress is being made in early detection, research and treatment programs for some cancers, this is clearly not the case for pancreatic cancer.

Pancreatic cancer is the deadliest cancer for one reason: limited Federal funding opportunities discourage researchers from pursuing pancreatic cancer as a focus. There are less than 15 fully-funded researchers nationwide who are specifically dedicated to this disease. The combination of few dollars and few researchers means there has been very little scientific progress.

PanCAN has outlined opportunities below for the Federal Government to take specific actions to facilitate progress in combating this disease.

Provide Adequate Funding Increases for Cancer Research, Prevention, and Treatment Programs

Pancreatic cancer is the country's fourth leading cause of cancer death, killing over 33,730 people annually, yet it remains severely under-funded when comparing NCI funding levels for the top five cancers based on mortality. The NCI spent a reported $66 million on pancreatic cancer research in fiscal year 2005, yet the other four top cancers (in mortality) are funded at levels at least four times this amount. Further, the discrepancy in funding has existed for many years, only compounding this inconsistency.

PanCAN supports the highest possible funding increase that Congress can provide for the National Institute of Health (NIH) and the NCI in fiscal year 2007. With additional funding for both the NIH and the NCI, new research grants can be awarded to fulfill the research goals identified by the NCI as essential to combating this disease. PanCAN is a member of the "One Voice Against Cancer" (OVAC) coali-

tion which is comprised of more than 50 cancer advocacy organizations that have come together to support our common goal: increased Federal funding for cancer research, prevention and training programs that are funded through the NIH, NCI and Centers for Disease Control and Prevention (CDC).

PanCAN wholeheartedly endorses OVAC's proposed fiscal year 2007 funding requests that seek a 5 percent increase for both the NIH and NCI. We urge you to provide a minimum of $29.7 billion for the NIH in fiscal year 2007. Separate testimony submitted to the Committee by OVAC reiterates the need for additional Federal funding for biomedical research: "The tremendous investment our Nation has made in the NIH has reaped remarkable returns and set the table for a period of unparalleled innovation in the fight against cancer and other diseases. For fiscal year 2007, OVAC joins with the broader public health community and urges Congress to provide $29.7 billion for the NIH. This is the minimal level of funding that will allow the NIH to maintain the current pace of discovery and innovation."

PanCAN also supports the NCI Director's Professional Judgment Budget, which calls for a total of $5.9 billion for the NCI in fiscal year 2007. Those within the agency and very knowledgeable of the research being conducted by the NCI have developed this plan and accompanying budget that seeks to investigate the most promising research available to the community at this time. We urge the Committee to do all that it can to support investments in biomedical research that will save lives. At a minimum, we urge the Committee to support a funding increase of 5 percent above last year's level for the NCI, which would bring the agency's fiscal year 2007 funding level to $5.034 billion. This funding level would provide an additional $240 million to at least keep the existing level of research at the NCI moving forward at a stable pace and thus protect the current number of investigator grant awards from significant cuts.

Ensure that Pancreatic Cancer Research is Not Compromised as the NCI Shifts its Focus from Disease Specific Research to More Global Science Initiatives

Last year, PanCAN requested that the Committee oversee implementation of the short, medium, and long-term strategies as identified in the Pancreatic Cancer Progress Review (PRG). The PRG has been in place since September 2002 and yet, 4 years later, few of these strategies have been implemented. For this reason, PanCAN urges the Committee to require the NCI to implement, in fiscal year 2007, all of the outstanding strategies as identified in the NCI implementation plan for pancreatic cancer PRG recommendations.

Through conversations and meetings with NCI leadership, we've learned about the shift in the NCI's focus on research. Disease specific science is being shelved in favor of sexier initiatives in the areas of nanotechnology, genomics, and the development of a biospecimen repository.

As the NCI moves its scientific agenda forward in these three areas, PanCAN is concerned that critical resources will be taken away from the significant investments that have been made in research related to early detection, diagnosis and treatment protocols for specific cancers. Other cancers have achieved significant declines in their respective mortality rates after early detection protocols have been developed. Since there is no such tool for diagnosing pancreatic cancer early in its development, the mortality rates remain high, and tens of thousands of patients are lost each year. As the advocacy community for pancreatic cancer patients, we feel that the NCI cannot justify any reductions in funding for pancreatic cancer research until significant reductions are achieved in the mortality rate for this cancer.

PanCAN urges the Committee to obtain assurance from the NCI that the cornerstone research of the agency will not be diminished as these new scientific initiatives are pursued. Further, PanCAN urges the Committee to direct the NCI to develop a written report that specifically details how these three major scientific initiatives will specifically advance pancreatic cancer research and submit this report to the Committee by April 1, 2007.

Support Selected Opportunities for Advancement of Pancreatic Cancer Research to Capitalize on the Initial Investment of Disease Specific Research

Identify genetic factors, environmental factors, and gene-environment interactions that contribute to pancreatic cancer development.

Achieve a more complete understanding of the biology of the normal pancreas and the development of pancreatic adenocarcinoma and use this knowledge to improve prevention, early detection, and treatment interventions.

Develop nationwide tissue and data repositories, molecular profiling resources, and bioinformatics tools for pancreatic cancer research. Use these resources to develop prevention and early detection interventions that are based on molecular features of pancreatic cancer.

Establish models for the study of environmental factors, gene-environment interactions, chemoprevention, chemotherapy, radiation therapy, vaccines, and imaging to improve understanding of pancreatic cancer risk, prevention, diagnosis, and treatment.

Identify and develop surveillance and diagnosis methods for early detection of pancreatic cancer and its precursors.

Develop and establish sustained, expanded training and career development efforts in pancreatic cancer research and care to build a comprehensive, multidisciplinary research community focused on this disease.

Mr. Chairman, the scientific community—through research—is making great progress in combating cancer. More people are surviving cancer today than any other time in history. Unfortunately, these achievements are not extended to the vast majority of pancreatic cancer patients. We urge you to provide America's world-renowned research enterprise with the funding levels necessary for investigators to continue to work their magic and develop screening protocols, effective treatments and therapies that will one day lead to the eradiation of all cancers—including pancreatic. To quote Congressman Clay Shaw (R-FL), a cancer patient, "When you approach the finish line, you don't walk . . . you run!" If the United States truly seeks to move forward with its ambitious goal to stop pain and death from cancer by 2015, it is imperative that Federal research programs be adequately funded to achieve this goal. On behalf of the 33,730 patients diagnosed with pancreatic cancer in 2006, I urge you to support increased funding for cancer research, treatment and prevention programs in your fiscal year 2007 bill.

PREPARED STATEMENT OF PEOPLE FOR THE ETHICAL TREATMENT OF ANIMALS

People for the Ethical Treatment of Animals (PETA) represents more than 1.3 million Americans who support the Federal Government's ongoing commitment to develop scientifically valid safety tests to protect human health and the environment from chemical hazards while reducing, and ultimately replacing, the use of animals. Thank you for the opportunity to present testimony relevant to the fiscal year 2007 budget request for the National Institute of Environmental Health Sciences in relation to the National Toxicology Program (NTP).

HISTORY OF THE NTP

The NTP was established in 1978 to provide information about potentially toxic chemicals and to coordinate toxicity testing programs within the Federal Government, strengthen the science of toxicology, and develop and validate improved testing methods. Three agencies form the core of the NTP: the National Institute of Environmental Health Sciences of the National Institutes of Health (NIEHS/NIH), the National Institute of Occupational Safety and Health of the Centers for Disease Control and Prevention (NIOSH/CDC), and the National Center for Toxicological Research of the Food and Drug Administration (NCTR/FDA). The NTP's activities are funded through the NIEHS at an annual level of approximately $500 to $600 million.[1]

NTP RODENT CANCER TESTING PROGRAM

During the 1960s and 70s, as vast numbers of new chemicals were being produced and used in agriculture, manufacturing, food preparation, and virtually every other aspect of modern life, the public became increasingly concerned that these chemicals were finding their way into the environment and food supply. Since much of the public anxiety regarding chemicals related to their potential to cause cancer, the Federal Government instituted a program to assess the cancer-causing potential of chemicals using rats and mice—on the assumption that rodent carcinogens could also present a cancer risk to humans. This rodent cancer-testing program began under the auspices of the National Cancer Institute, but has been managed by the NTP since its inception in 1968.

A conventional NTP rodent cancer study takes approximately 5 years to design, conduct and interpret, consuming at least 860 animals and up to $4 million per chemical tested.[2] The study exposes three groups of animals to three different doses

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[1] White House Office of Technology Assessment. Researching health risks. Washington, DC: EOP (1993).

[2] NIEHS Fact Sheet: The National Toxicology Program. Research Triangle Park, NC: NIEHS (1996).

of a test chemical, while a fourth group (known as the "control" group) receives no chemical exposure. The chemically exposed animals receive daily doses of a test substance for their entire 18- to 24-month life span. If these animals develop more tumors than the non-chemically exposed controls, this is taken as evidence that a chemical causes cancer. To date, the NTP has tested hundreds of substances in rodent cancer studies—including pharmaceuticals, pesticides, plastics, industrial chemicals, and even plant extracts—at a projected cost of more than 1 billion U.S. taxpayer dollars.[3]

A HISTORY OF CONTROVERSY

The NTP recently celebrated the publication of its 500th rodent cancer study as "the gold standard in animal toxicology."[4] However, in contrast to the fanfare with which this announcement was made, the history of NTP rodent cancer studies is one of controversy spanning several decades, with top Federal officials admitting:

"The current 2-year rodent carcinogenicity study was never validated and there is little evidence supporting the repeatability and reproducibility of the current rodent carcinogenicity study."[5]

—Drs. Joseph Contrera, Abigail Jacobs, and Joseph DeGeorge
Food and Drug Administration, Center for Drug Evaluation and Research

"We have been concerned about the predictivity of 2-[year] [rodent cancer studies] for the past 10 [years], as our experience and knowledge have expanded."[6]

—Drs. Bernard Schwetz and David Gaylor
Food and Drug Administration, Office of the Director/National Center for Toxicological Research

"The problem is we don't know what the findings really mean."[7]

—Dr. Robert Maronpot, chief, Laboratory of Experimental Pathology,
National Institute of Environmental Health Sciences (NIEHS)

"Even if a chemical is found to be nontoxic in animal studies, the safety of the chemical cannot be assured."[8]

—Dr. Barbara Shane, NTP executive secretary

"I have to say we don't serve the American people very well right now."[6]

—Dr. Kenneth Olden, director, NTP & NIEHS (1991–2005)

PETA'S ANALYSIS

PETA recently conducted an in-depth analysis of all 502 federally funded and conducted lifetime rodent cancer studies published on the NTP website as of January 2006.[9] On the basis of this analysis, together with more than 25 years of published scientific literature on this subject, we have determined that:

—The great majority of the U.S. Government's more than $1 billion investment in the NTP rodent cancer-testing program has produced little or no actual benefit, having been used to underwrite studies that:
  —Have been judged by the NTP itself to be "inadequate" or to produce "equivocal" (ambiguous) results, which are of no use to health authorities ($121 million).
  —Have produced such dubious and conflicting results that more than 75 percent of tested chemicals remain either unclassified as to their cancer risk to humans, or are lumped into such meaningless categories as "possible" human carcinogens or "unclassifiable" as to human cancer risk—designations that do nothing to enhance public health or worker protection ($460–720 million).
  —Have been shown by other scientists to produce consistent and reproducible results only 57 percent of the time when the same chemicals are tested more

[3] 502 lifetime cancer studies in rats and mice × $2–4 million/study = $1–2 billion.

[4] NIEHS News Release: NTP completes 500th two-year rodent study and report; series is the gold standard of animal toxicology. 25 Jan 2001. <http://www.niehs.nih.gov/oc/news/ntp500.htm>.

[5] Contrera JF, Jacobs AC, DeGeorge JJ. Carcinogenicity testing and the evaluation of regulatory requirements for pharmaceuticals. Regulatory Toxicology and Pharmacology 25, 130–145 (1997).

[7] Brinkley J. Many say lab-animal tests fail to measure human risk. The New York Times 1993 Mar 23;Sect A:1.

[8] Shane BS. Human reproductive hazards. Environmental Science and Technology 30, 1193 (1989).

[6] Schwetz B, Gaylor D. New directions for predicting carcinogenesis. Molecular Carcinogenesis 20, 2 75–279 (1997).

[9] PETA's full report is available upon request or may be downloaded from http://www.stopanimaltests.com/u-ntp.asp.

than once using the same method—a result that could be achieved by simply tossing a coin.

—Critical public health and worker protection measures related to cigarette smoke, asbestos, benzene, and other cancer-causing substances were delayed for many years because of misplaced trust in animal tests, which for years could not replicate cancerous effects that had already been documented in people.[10] [11] [12] [13] If standard animal tests failed to readily identify these well-known human carcinogens, how many other dangerous chemicals are Americans being exposed to today as a result of misleading animal data?

—Conversely, substances such as saccharin and ethyl acrylate (used in the manufacturing of latex paints and textiles) have been branded as "probable" human carcinogens and stigmatized on the basis of animal data later dismissed as irrelevant or otherwise inapplicable to humans.[14] False alarms such as these can cost society billions in terms of loss of viable products in commerce, decreased international competitiveness, job loss, litigation, and unnecessary public anxiety.

—Lifetime cancer studies in rats and mice are so costly and inefficient that the NTP has only been able to conduct an average of 12 such studies per year over the past several decades. At this rate, it would take the NTP more than 32,000 years, 68 million animals, and $160 billion to test the more than 80,000 environmental chemicals whose cancer-causing potential has not yet been specifically assessed.[15]

These findings call into question the wisdom of continued Federal appropriations to the NTP rodent cancer-testing program. Taxpayer dollars would be better spent developing more reliable, relevant, and cost-effective methods for assessing chemical safety.

NTP VISION AND ROADMAP FOR THE 21ST CENTURY

The NTP itself appears to recognize the limitations of relying upon decades old and never validated toxicity studies. In 2003, the NTP articulated its "vision" to move toxicology from an observational to a predictive science with markedly reduced reliance on animal testing.[16] Among the methods that the NTP has identified for further development are "high throughput" screens, which combine robotics and in vitro (cell-based) toxicology to create a system capable of rapidly and inexpensively screening tens of thousands of substances per year at multiple concentrations relevant to real-world human exposure levels. PETA believes that a "battery" of several in vitro tests—based on human tissues and mechanisms of cancer induction that are relevant to people (e.g., genetic damage, cell transformation, depression of the immune system, hormone imbalance, etc.) represents the most credible and viable approach to accurately identifying chemicals that pose a cancer risk to humans.

REQUEST FOR APPROPRIATIONS

In order to more rapidly and effectively screen chemicals to detect those that present a cancer risk to humans, we respectfully urge the subcommittee to support increasing appropriations from within the existing NIEHS budget for the development and validation of efficient and economical non-animal test methods under the NTP's "21st Century Vision" program.[16] Given the dubious value of the NTP rodent cancer-testing program, we respectfully recommend that funding of this program be discontinued and redirected instead to the NTP Vision program.

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[10] Laskin S, Sellakumar AR. Models in chemical respiratory carcinogenesis. In: Karbe E, Park JF, eds. Experimental lung cancer: carcinogenesis and bioassays. New York: Springer-Verlag (1974).

[11] Rodelsperger K, Woitowitz H–J. Airborne fiber concentrations and lung burden compared to the tumor response in rats and humans exposed to asbestos. Annals of Occupational Hygiene 39, 715–725 (1995).

[12] DeLore P, Borgomono C. Acute leukemia following benzene poisoning. Journal de MAE1decin de Lyon 9, 227–236 (1928).

[13] De Marini DM and others. Benchmarks: alternative methods in toxicology. MA Mehlman, ed. Princeton, NJ: Princeton Scientific Publishing (1989).

[14] NIEHS Fact Sheet: The Report on Carcinogens—9th edition. 15 May 2000. <http://www.niehs.nih.gov/oc/news/9thROC.htm>.

[15] Ward EM, Schulte PA, Bayard S, et al. Priorities for development of research methods in occupational cancer. Environmental Health Perspectives 111, 1–12 (2003).

[16] Toxicology in the 21st Century: The Role of the National Toxicology Program. 24 Feb 2004. <http://ntp-server.niehs.nih.gov/index.cfm?objectid=EE4AED80-F1F6-975E-7317D7CB17625A15>.

REQUEST FOR COMMITTEE REPORT LANGUAGE

We also respectfully request that the subcommittee consider the following report language for the Senate Labor, Health and Human Services, Education and Related Agencies Appropriations bill:

"Not later than March 30, 2007, the Director of the NTP/NIEHS shall provide Congress with a report detailing the number of rodent lifetime cancer studies funded to date by the NTP/NCI which (i) produced results deemed to be equivocal and/or inadequate for classification as to human cancer risk, or (ii) have failed to provide a clear answer as to whether the substance tested presents a cancer risk to humans. The Director's report should detail the costs associated with such studies, and explain the NTP's continued reliance on rodent lifetime cancer studies in light of criticisms from senior Federal officials regarding their dubious validity and utility."

Thank you for the opportunity to submit this request on behalf of our more than 1.3 million members and supporters.

PREPARED STATEMENT OF PROJECT R&R

Project R&R: Release and Restitution for Chimpanzees in U.S. Laboratories, whose advisory board of chimpanzee experts includes 12 organizations with a combined membership of 500,000, respectfully submits testimony on our funding priority.

We request that Federal funding for breeding chimpanzees for research, or for projects that require breeding, be terminated. We do so for the following reasons:

—A "surplus" of chimpanzees has resulted from over-breeding in the 1980s for HIV/AIDS research and later findings that they are a poor HIV/AIDS model.[1]
—There are enough chimpanzees to address existing federally funded research.[2]
—As a result of the "surplus," the government funds a national sanctuary system.[3]
—The current population costs about $11 million Federal per year.
—Breeding more chimpanzees increases taxpayers' financial burden.
—Expansion of the population compounds existing concerns about their quality of care.
—While there is a breeding moratorium, NIH still funds research projects requiring breeding.[4]
—The public is concerned about the use of chimpanzees in research.

Background.—Of an estimated 1,300 chimpanzees in laboratories in the United States today, approximately 850 are federally owned or supported. In the mid-1990s, the National Research Council (NRC) made recommendations to address the "surplus" that included a moratorium on breeding federally-owned or supported chimpanzees for at least 5 years[5] (implemented in 1995). The National Advisory Research Resources Council, which advises NCRR on funding activities, policies, and program, met on 09/15/05 and recommended that NCRR extend the moratorium to 12/07. The recommendation was accepted[6]—reasons included the high costs associated with care and the fact that chimpanzees are a poor model for human HIV research.[7] [8]

Circumventing the moratorium.—Despite the moratorium, NIH funds research projects requiring breeding. For example, the National Institute of Allergy and Infectious Diseases (NIAID) maintains a contract with the New Iberia Research Center (NIRC) to provide 10 to 12 infants annually for research. The 10 year contract entitled "Leasing of chimpanzees for the conduct of research' was allotted over $22 million ($3.9 million has been spent since 2002).[9]

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[1] National Research Council (1997) Chimpanzees in research: strategies for their ethical care, management and use. National Academies Press: Washington, D.C.
[2] Report of the Chimpanzee Management Plan Working Group to the National Advisory Research Resources Council; May 18, 2005.
[3] http://www.ncrr.nih.gov/compmed/cm__chimp.asp.
[4] Ibid.
[5] National Research Council (1997) Chimpanzees in research: strategies for their ethical care, management and use. National Academies Press: Washington, D.C.
[6] http://www.ncrr.nih.gov/compmed/cm__chimp.asp
[7] Muchmore, E., (2001) Chimpanzee models for human disease and immunobiology, Immunological Reviews, 183, 86–93.
[8] Reynolds, V., (1995) Moral issues in relation to chimpanzee field studies and experiments, Alternatives to Laboratory Animals, 23, 621–625.
[9] Source: http://dcis.hhs.gov/nih/nih__daily__active__web.html (See contract No. 272022754).

NIRC has also received $5.47 million from 09/00 to 08/05 for a grant from NCRR to maintain 138 chimpanzees for breeding. NIH/NCRR spends more than $1 million annually to maintain the NIRC breeding colony.[10] These grants result in $9 million going to breeding-related activities at NIRC alone since 2000.

Such expenditures circumvent the intent of the breeding moratorium, compelling the need to prevent the growing financial burden of increasing numbers of chimpanzees, particularly since, by the government's own admission, a "surplus" already exists.

Costs for Chimpanzee Maintenance.—The cost of care for chimpanzees is a major concern, particularly with NIH's tightening budget. In 1995, the Institute for Laboratory Animal Research (ILAR) published a study that projected the future costs of maintaining chimpanzees in U.S. research.[11] ILAR, a division of the National Academies of Science, functions as "an advisor to the Federal Government, the biomedical research community, and the public."[12]

The ILAR study examined the per diem costs of the existing population of chimpanzees at six facilities. Taking into account a variety of factors such as longevity, distribution of sex, and complexity of care, it projected costs of maintaining the present colony over the next 60 years. To account for inflation, an annual 4 percent increase was incorporated, corresponding approximately to the Biomedical Research and Development Price Index.

The results of the study indicated that the lifetime cost of maintaining chimpanzees over the next 60 years—the approximate lifespan of chimpanzees in captivity—will exceed $3.14 billion. The 1995 projection, however, was based on a population of 1,447 chimpanzees. The present population of federally owned or supported chimpanzees in 2006, due to implementation of the partial breeding moratorium in 1995 and the close of the Coulston Foundation in 2002, stands closer to 850. This represents approximately 59 percent of the 1,447 number used in ILAR's projection. Thus we can estimate the cost of the existing colony to be $1.85 billion.

The ILAR projection also concluded that the current 2006 annual costs would be approximately $18.8 million. Adjusting this number by 59 percent results in $11 million spent in 2006 alone to maintain chimpanzees for research.

It is important to note that $11 million represents only a partial estimate of the entire Federal expenditure for chimpanzee research. The total population of U.S. chimpanzees available for research is estimated at 1,300. Approximately 500 of these chimpanzees are privately owned. Privately owned chimpanzees are also partially funded by Federal research dollars. Therefore, the 2006 estimate of annual expenditure actually exceeds $11 million by an undetermined amount.

Delivery of care.—USDA inspection reports indicate that facilities housing chimpanzees for research are not adequately meeting basic housing needs. Inspection reports for the NIRC 2004 showed some chimpanzees being housed in less than the minimal space requirements. The facility was given one year to correct the non-compliance, which needed to be further extended as construction of new housing facilities was still not completed. NIRC was also cited 7 times during its 12/04 inspection for improperly sanitizing cages and living quarters, as well as for failing to provide adequate environment enhancement.

Inspection reports filed on the Southwest Foundation for Biomedical Research and the Yerkes Primate Facility, both National Primate Research Centers, also demonstrate multiple non-compliant items for failing to keep chimpanzee areas in well-maintained condition, and failing to maintain safe facilities free of dangers due to disrepair.

A poor model.—It is widely agreed within the scientific community that chimpanzees are a poor model for HIV. Years of research demonstrated that HIV-infected chimpanzees do not develop AIDS. Similarly, while chimpanzees are used in current hepatitis C research, they do not model the course of the human disease. The decoding of the chimpanzee genome pointed out similarities as well as differences between humans and chimpanzees. Some of those greatest differences relate to the immune system.[13] Such differences question the validity of using chimpanzees in infectious disease research, further arguing the need to curb populations and costs.

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[10] http://nirc.louisiana.edu/divisions/nihgrants.html

[11] Dyke, B., Williams-Blangero, S. et al, 1995 "Future costs of chimpanzees in U.S. research institutions," ILAR Journal V37(4) http://dels.nas.edu/ilar__/ilarjournal/37__4/37__Future.shtml

[12] Institute for Laboratory Animal Research, website at http://dels.nas.edu/ilar__n/ilarhome/about.shtml

[13] The Chimpanzee Sequencing and Analysis Consortium/Mikkelsen, TS, et al.,(1 September 2005) Initial sequence of the chimpanzee genome and comparison with the human genome, Nature 437, 69–87.

Ethical concerns.—The U.S. public is concerned about the use of chimpanzees in research because of their intellectual, emotional and social similarities to humans. A 2005 poll conducted by the Humane Research Council revealed that 4 out of 5 (83 percent) of the U.S. public recognize chimpanzees as highly intelligent, social individuals who have an extensive capacity to communicate. A full 71 percent of Americans support the release of chimpanzees if they have been used in research for more than 10 years.[14] A 2001 poll conducted by Zogby International showed that 90 percent of Americans believe it is unacceptable to confine chimpanzees in government-approved cages.[15]

Conclusion.—We respectfully request that the following language appear in the House Labor, Health and Human Services, Education and Related Agencies Appropriations Subcommittee Report for Fiscal Year 2007:

"None of these funds shall be used for the breeding of chimpanzees or research projects that require the breeding of chimpanzees."

We hope the committee will accommodate this modest request that will save the government substantial money, benefit chimpanzees, and allay some concerns of the public at large. Thank you for your consideration.

LETTER FROM SENATOR PAT ROBERTS, ET AL.

WASHINGTON, DC, *April 5, 2006.*

Hon. ARLEN SPECTER, *Chair,*
Hon. TOM HARKIN, *Ranking Member,*
Subcommittee on Labor, HHS, and Education, Senate Committee on Appropriations, Washington, DC

DEAR CHAIRMAN SPECTER AND RANKING MEMBER HARKIN: As you begin your work on the fiscal year 2007 Labor, Health and Human Services, and Education Appropriations bill, we urge you to provide the same level of funding for Title VII health professional as was appropriated in fiscal year 2005 ($299,552,000). These programs provide direct financial support for health care workforce development and education. In addition, they are the only Federal programs designed to train providers in interdisciplinary setting to respond to the needs of special and underserved populations. They also work to increase minority representation in the health care workforce.

The fiscal year 2006 Labor, Health and Human Services, Education Appropriations bill dramatically reduced funding for Title VII health professions programs, resulting in a 51 percent overall cut below fiscal year 2005. At a time of serious health professions shortages, this reduction has already had devastating effects on the country's neediest communities. By restoring funding to these programs to fiscal year 2005 levels, you will enable them to continue to improve the distribution, quality, and diversity of the health professions workforce.

We respectfully urge you to restore funding to the Title VII programs in the fiscal year 2007 Labor, Health and Human Services, and Education appropriations bill. We greatly appreciate your consideration of the request.

Sincerely,

Senators Pat Roberts, Jack Reed, Elizabeth Dole, Daniel K. Akaka, Susan M. Collins, Lamar Alexander, Richard Durbin, Sam Brownback, Blanche L. Lincoln, Richard G. Lugar, James M. Jeffords, Paul S. Sarbanes, Norm Coleman, Charles E. Schumer, Byron L. Dorgan, Frank R. Lautenberg, Dianne Feinstein, Mark L. Pryor, Hillary Rodham Clinton, Evan Bayh, Christopher J. Dodd, Patrick J. Leahy, John F. Kerry, Tim Johnson, Debbie Stabenow, Jon Kyl, Ken Salazar, Bill Nelson, Benjamin E. Nelson, Edward M. Kennedy, Robert Menendez, Barbara A. Mikulski, Russell D. Feingold, George V. Voinovich, Mary L. Lanorieu, Maria Cantwell, Barack Obama, Joseph I. Lieberman, Jeff Bingaman, Harry Reid, John D. Rockefeller, IV, Conrad Burns, Barbara Boxer, Mark Dayton, Lincoln Chafee, Patty Murray, Christopher S. Bond, Carl Levin, Mike DeWine, Chuck Hagel, John Warner, Lindsey Graham, Richard M. Burr, James M. Talent, Jeff Sessions, and Ron Wyden.

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[14] U.S. Public Opinion of Chimpanzee Research, Support for a Ban, and Related Issues, Prepared for the New England Anti-Vivisection Society, by the Humane Research Council, 2005.

[15] Public Opinion Poll, Prepared for the Chimpanzee Collaboratory, by Zogby International, 2001.

PREPARED STATEMENT OF THE SPINA BIFIDA ASSOCIATION

On behalf of the more than 70,000 individuals and their families who are affected by Spina Bifida, the Spina Bifida Association (SBA) appreciates the opportunity to submit written testimony for the record regarding fiscal year 2007 funding for the National Spina Bifida Program and other related Spina Bifida initiatives. SBA is the national voluntary health agency working on behalf of people with Spina Bifida and their families through education, advocacy, research and service. The Association was founded in 1973 to address the needs of the Spina Bifida community and today serves as the representative of 56 chapters serving more than 125 communities nationwide. SBA stands ready to work with Members of Congress and other stakeholders to ensure our Nation takes all the steps necessary to reduce and prevent suffering from Spina Bifida.

BACKGROUND ON SPINA BIFIDA

Spina Bifida, a neural tube defect (NTD), occurs when the spinal cord fails to close properly during the early stages of pregnancy, typically within the first few weeks of pregnancy and most often before the mother knows that she is pregnant. Over the course of the pregnancy—as the fetus grows—the spinal cord is exposed to the amniotic fluid which increasingly becomes toxic. It is believed that the exposure of the spinal cord to the toxic amniotic fluid erodes the spine and results in Spina Bifida. There are varying forms of Spina Bifida occurring from mild—with little or no noticeable disability—to severe—with limited movement and function. In addition, within each different form of Spina Bifida the effects can vary widely. Unfortunately, the most severe form of Spina Bifida occurs in 96 percent of children born with this birth defect.

The result of this neural tube defect is that most children with it suffer from a host of physical, psychological, and educational challenges—including paralysis, developmental delay, numerous surgeries, and living with a shunt in their skulls which seeks to ameliorate their condition by helping to relieve cranial pressure associated with spinal fluid that does not flow properly. As we have testified previously, the good news is that after decades of poor prognoses and short life expectancy, children with Spina Bifida are now living long enough to become adults with Spina Bifida. These gains in longevity principally are due to breakthroughs in research, combined with improvements generally in health care and treatment. However, with this extended life expectancy, our Nation and people with Spina Bifida now face new challenges—education, job training, independent living, health care for secondary conditions, aging concerns, among others. Despite these gains, individuals and families affected by Spina Bifida face many challenges—physical, emotional, and financial. Fortunately, with the advent of the National Spina Bifida Program 4 years ago, individuals and families affected by Spina Bifida now have a national resource to provide them with the support, information, and assistance they need and deserve.

While the consumption of 400 micrograms of folic acid daily prior to becoming pregnant and throughout the first trimester of pregnancy, can help reduce the incidence of Spina Bifida by up to 75 percent, cases of Spina Bifida still occur and our Nation still must take steps to ensure that the tens of thousands of individuals living with Spina Bifida can live full, healthy, and productive lives. To ensure the highest quality-of-life possible, prevention interventions and treatment therapies must be identified, developed, and delivered to those in need.

COST OF SPINA BIFIDA

It is important to note that the lifetime costs associated with a typical case of Spina Bifida—including medical care, special education, therapy services, and loss of earnings—are as much as $1 million. The total societal cost of Spina Bifida is estimated to exceed $750 million per year, with just the Social Security Administration payments to individuals with Spina Bifida exceeding $82 million per year. Moreover, tens of millions of dollars are spent on medical care paid for by the Medicaid and Medicare Programs. Our Nation must do more to help reduce the emotional, financial, and physical toll of Spina Bifida on the individuals and families affected. Efforts to reduce and prevent suffering from Spina Bifida help to save money and save lives.

IMPROVING QUALITY-OF-LIFE THROUGH THE NATIONAL SPINA BIFIDA PROGRAM

SBA has worked with Members of Congress to ensure that our Nation is taking all the steps possible to prevent Spina Bifida and diminish suffering for those currently living with this condition. With appropriate, affordable, and high-quality medical, physical, and emotional care, most people born with Spina Bifida likely will

have a normal or near normal life expectancy. Ensuring access to these services is essential to improving the quality-of-life for those born with this birth defect.

The National Spina Bifida Program at the National Center for Birth Defects and Developmental Disabilities (NCBDDD) at the Centers for Disease Control and Prevention (CDC) works on two critical levels—to reduce and prevent Spina Bifida incidence and morbidity and to improve quality-of-life for those living with Spina Bifida. The program seeks to ensure that what is known by scientists is practiced and experienced by the 70,000 individuals and families affected by Spina Bifida. Moreover, the National Spina Bifida Program works to improve the outlook for a life challenged by this complicated birth defect—principally identifying valuable therapies from in-utero throughout the lifespan and making them available and accessible to those in need.

The National Spina Bifida Program serves as a national center for information and support to help ensure that individuals, families, and other caregivers, such as health professionals, have the most up-to-date information about effective interventions for the myriad primary and secondary conditions associated with Spina Bifida. Among many other activities, the program helps individuals with Spina Bifida and their families learn how to treat and prevent secondary health problems, such as bladder and bowel control difficulties, learning disabilities, depression, latex allergy, obesity, skin breakdown and social and sexual issues. Children with Spina Bifida often have learning disabilities and may have difficulty with paying attention, expressing or understanding language, and grasping reading and math. All of these problems can be treated or prevented, but only if those affected by Spina Bifida—and their caregivers—are properly educated and taught what they need to know to maintain the highest level of health and well-being possible. The National Spina Bifida Program's secondary prevention activities represent a tangible quality-of-life difference to the 70,000 individuals living with Spina Bifida with the goal being living well with Spina Bifida.

In fiscal year 2006, Congress folded funding for a study on folic acid (also known as the "China Study") into the National Spina Bifida Program and provided $5.1 million in fiscal year 2006 (a final allocation of $5 million after the one percent across-the-board cut) for this new joint program. SBA appreciates Congressional interest and intent in ensuring that the CDC's folic acid and Spina Bifida activities are coordinated. SBA maintains a strong interest in working with NCBDDD and Members of the subcommittee to ensure that this new joint program fulfills Congressional intent and that the quality-of-life components of the National Spina Bifida Program receive adequate funding to support ongoing and expanded endeavors.

SBA advocates that the National Spina Bifida Program receive $6 million in fiscal year 2007 and that that sum be used to expand and continue to promote quality-of-life programs that support people with Spina Bifida so they can live fulfilling and productive lives. In its first 3 years, this program already has made a difference for our community and with additional resources it can expand its reach and provide additional assistance and hope to those with an affected loved one. Increasing funding for the National Spina Bifida Program will help ensure that our Nation continues to mount a comprehensive effort to prevent and reduce suffering from Spina Bifida.

PREVENTING SPINA BIFIDA

While the exact cause of Spina Bifida is unknown, over the last decade, medical research has confirmed a link between a woman's folate level before pregnancy and the occurrence of Spina Bifida. Sixty million women are at-risk of having a child born with Spina Bifida and each year approximately 3,000 pregnancies in this country are affected by Spina Bifida, resulting in 1,500 births. As mentioned above, the consumption of 400 micrograms of folic acid daily prior to becoming pregnant and throughout the first trimester of pregnancy can help reduce incidence of Spina Bifida up to 75 percent. There are few public health challenges that our Nation can tackle and conquer by three-fourths in such a straightforward fashion. However, we must still be concerned with addressing the 25 percent of Spina Bifida cases that cannot be prevented by folic acid consumption, as well as ensuring that all women of childbearing age—particularly those most at-risk for a Spina Bifida pregnancy—consume adequate amounts of folic acid.

The good news is that progress has been made in convincing women of the importance of folic acid consumption and the need to maintain diet rich in folic acid. Since 1968, the CDC has led the Nation in monitoring birth defects and developmental disabilities, linking these health outcomes with maternal and/or environmental factors that increase risk, and identifying effective means of reducing such risks.

Former CDC Director Jeff Koplan has stated that the agency's folic acid prevention campaign has reduced neural tube defect births by 20 percent. This public health success should be celebrated, but it is only half of the equation as approximately 3,000 pregnancies still are affected by this devastating birth defect. The Nation's public education campaign around folic acid consumption must be enhanced and broadened to reach segments of the population that have yet to heed this call—such an investment will help ensure that as many cases of Spina Bifida can be prevented as possible.

SBA works collaboratively with CDC and the March of Dimes to increase awareness of the benefits of folic acid, particular for those at elevated risk of having a baby with neural tube defects (those who have Spina Bifida themselves or those who have already conceived a baby with Spina Bifida). With additional funding in fiscal year 2007 these activities could be expanded to reach the broader population in need of these public health education, health promotion, and disease prevention messages. SBA advocates that Congress provide additional funding to CDC to allow for a particular public health education and awareness focus on at-risk populations (e.g. Hispanic-Latino communities) and health professionals who can help disseminate information about the importance of folic acid consumption among women of childbearing age.

In addition to a $6 million fiscal year 2007 allocation for the National Spina Bifida Program, SBA supports a fiscal year 2007 allocation of $135 million for the NCBDDD so the agency can enhance its programs and initiatives to prevent birth defects and developmental disabilities and promote health and wellness among people with disabilities.

IMPROVING HEALTH CARE FOR INDIVIDUALS WITH SPINA BIFIDA

The mission of the Agency for Healthcare Research and Quality (AHRQ) is to improve the outcomes and quality of health care; reduce its costs; improve patient safety; decrease medical errors; and broaden access to essential health services. The work conducted by the agency is vital to the evaluation of new treatments in order to ensure that individuals and their families living with Spina Bifida continue to receive the high quality health care that they need and deserve—SBA recommends that AHRQ receive $443 million in fiscal year 2007 so that it can continue to conduct follow-up efforts to evaluate Spina Bifida treatments, promulgate associated standards of care, and further the provision of evidence-based care stemming from the outcomes of the 2003 Spina Bifida Research Conference.

SUSTAIN AND SEIZE SPINA BIFIDA RESEARCH OPPORTUNITIES

SBA seeks to support individuals and families affected by Spina Bifida, maximize the prevention of Spina Bifida, and ensure that all babies born with Spina Bifida have the greatest chance of survival and the highest quality-of-life—through the lifespan. When families recently diagnosed with a Spina Bifida pregnancy contact SBA, the organization puts them in touch with another family who has a child with the condition so they can learn of the joys and challenges of having a child with the birth defect. Unfortunately, traditionally when families have faced a Spina Bifida diagnosis they have had two difficult options. The first is to continue the pregnancy with the expectation of multiple surgeries for the child after birth, uncertain life expectancy, and many physical and developmental challenges and complications. The second, unfortunately, is to terminate the pregnancy. Fortunately, now there may be an important and effective third option.

Since the late 1990s, doctors at three U.S. hospitals—Children's Hospital of Philadelphia, Vanderbilt University Medical Center in Nashville, and the University of California at San Francisco—have been operating before birth on fetuses diagnosed with Spina Bifida. In 2004, the University of North Carolina became the fourth hospital in the Nation to perform the in-utero operations. By closing the spinal lesion early in pregnancy, physicians believe they can minimize the damage created by fluid leaking from the spine, as well as limit by the harm done due to the spinal cord's contact with the amniotic fluid. Surgeons have found that closing the hole in the spine in this fashion before birth may correct breathing problems in 15 percent of the children receiving the procedure and may reduce the need for a shunt to drain fluid from the brain by between 33 percent and 50 percent.

To determine whether or not this new procedure is safer and more effective than the traditional post-birth surgery to address the condition, the National Institute of Child Health and Human Development (NICHD) is conducting a large study involving the Children's Hospital of Philadelphia, Vanderbilt University Medical Center, and the University of California at San Francisco. While these three institutions have undertaken preliminary studies of the in-utero surgery technique, the overall

and long-term effectiveness of this approach as compared to traditional therapy remains unknown. Given the potential for this surgery to ameliorate many of the conditions associated with Spina Bifida, we must do a better job of studying and evaluating this procedure, educating health care providers about this surgery as a potential option, and making information about it available to more families facing a Spina Bifida pregnancy.

Additionally, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) is scheduled to host an interagency meeting in spring 2006 on urological complications. We are also excited to report that the National Institute of Neurological Disorders and Stroke (NINDS) has formed a trans-agency Spina Bifida Working Group. SBA looks forward to working with both agencies on these and other important Spina Bifida related initiatives.

Our Nation has benefited immensely from our past Federal investment in biomedical research at the National Institutes of Health (NIH). SBA joins with the rest of the public health community in advocating that NIH receive $29.7 billion in fiscal year 2007. This funding will support applied and basic biomedical, psychosocial, educational, and rehabilitative research to improve the understanding of the etiology, prevention, cure and treatment of Spina Bifida and its related conditions. In addition, SBA urges the NIH to explore the following as they relate to individuals with Spina Bifida: assistive technology, in utero surgery, cost of care, women's and men's health, tethered spinal cord, hydrocephalus, latex allergies, and other related factors.

CONCLUSION

SBA stands ready to work with policymakers to advance policies that will reduce and prevent suffering from Spina Bifida. Again, we thank you for the opportunity to present our views on funding for programs that will improve the quality-of-life for the 70,000 Americans and their families living with Spina Bifida and stand ready to answer any questions you may have.

PREPARED STATEMENT OF THE TUOMEY HEALTHCARE SYSTEM

Mr. Chairman, and Members of the subcommittee, thank you for the opportunity to submit testimony regarding the need for a Bedside Medication Verification System and subsequently a Computerized Practitioner Order Entry and Clinical Decision Support System at Tuomey Healthcare System.

For more than 90 years, Tuomey's growth and advancement have been guided by professionals who care deeply about the Sumter community and the individual healthcare needs of every person in it. From the small 20-bed Sumter Hospital born out of Timothy Tuomey's gift in 1913 to a healthcare system of more than 1,600 employees and 266 beds, Tuomey's history has been one of compassion and resolve. It is propelled by a long-term vision for healthcare that's second to none and is enhanced by a deeply philanthropic mission.

Since 2000, Tuomey has provided tens of millions of dollars in community services. And each year, we absorb almost $20 million in indigent care. Our employee base is tremendously dedicated to Sumter's health as well, as evidenced by their gift of close to $1 million since 2000. Through all of this, Tuomey is committed to Sumter, and it shows in everything we do. In the last year, Tuomey has ranked in the 97th and 98th percentiles nationally in the Press Ganey customer satisfaction scores in the inpatient and ambulatory surgery center categories.

The demand for Tuomey services will be further increased with the upcoming addition of approximately 850 service men and women to Shaw Air Force Base and the closing of the base's inpatient hospital. This equates to an approximate 3,000 person increase in total population to the Sumter community. To handle Tuomey's additional patient volume and to continue providing the quality care for which we are known, it is imperative we increase our inpatient capacity. Likewise, we must expand our women's and obstetrics service areas and our Emergency Department to meet the growing needs of this community. It is an expensive proposition, but one to which we are committed. It's the next step in our path to safeguarding this community's health.

Plans are currently underway for the construction of a new 24-bed women's complex called The Tuomey Women's Center, expansion and enhancement of our nurseries, the addition of 22 general medical inpatient rooms, and the expansion of the Emergency Department. The total combined cost of these expansions and enhancements is $31.5 million.

High quality care and patient safety are the core elements of everything we do at Tuomey, utilizing technology where appropriate and cost effective. We have been

a Meditech Information Systems customer since 1988, with virtually every department in our facility computerized, to include nursing documentation, radiology results, laboratory results and all financials. In July 2005, we went live with the McKesson Electronic Medical Record, which allows physicians to access patient information from anywhere with an internet connection, enhancing the timely delivery and continuity of care. However, even with the benefits gained from our technology, we still deal with the challenges of caring for sicker patients in a shorter period of time with limited financial resources and shortages of skilled labor. Like many other hospitals, a completely safe and accurate medication management process remains one of our most difficult challenges. In addition, the medication management process is one of the areas where technology can offer the greatest number of improvements in terms of patient safety and quality of care.

In its 1999 report, "To Err is Human: Building a Safer Health System," The Institute of Medicine (IOM) estimated that 44,000 to 98,000 patients die each year from medical errors, of which the largest portion, up to one-third, has been linked to medication errors or adverse drug events (ADEs). A medication error can lead to increased charges and longer patient stays while adverse drug events can lead to patient injury and death. While there is a difference between medication errors and adverse drug events, Tuomey's goal is to avoid both and to consistently offer the highest quality care in the safest patient care environment possible.

Medication administration safety is dependent on five basic safety checks: the correct patient, the correct drug, the correct dose, the correct route of administration and the correct time of administration. Any deviation from these five standards of medication administration practice can lead to medication errors and Adverse Drug Events. Given that there are now more than 17,000 brand and generic names for pharmaceuticals in North America and nurses are caring for sicker patients on shorter hospital stays, the implementation of automated systems to safeguard against human errors in all aspects of the medication administration process has reached a state of critical need at Tuomey.

Currently, Tuomey is using an antiquated, yet not uncommon, system of medication ordering in which providers handwrite orders that are sent via pneumatic tube to a pharmacy location. The pharmacy staff deciphers the handwritten orders to the best of their human ability and sends the medications to the nursing staff that then rely on handwritten orders and the five rights of medication administration. In addition, the pharmacy charges the patient's account for the medications at the point the medications are dispensed from the pharmacy. The pharmacy is then responsible for crediting the patient's account if the medications are never taken.

The failure rate for this type of system is staggering throughout the healthcare community. Physicians, pharmacists, nurses and support staff work long hours with fluctuating levels of stress. Experts have estimated that at least 38 percent of all medication errors take place at the bedside using manual handwritten systems like the one currently in use at Tuomey. There are simply too many distractions and too many chances for something to go wrong when completely relying on protocols and procedures to assure safe and accurate medication administration. It is important to note, though, that Tuomey has never been complacent with a system that puts any patient at risk. Tuomey has remained vigilant to the risks associated with its current medication administration process and has made many improvements and changes to the manual system to promote patient safety and accuracy.

Unfortunately, for many years, there has not been a feasible alternative to the manual system. Technology and system availability have only recently reached a State worth investigating for true process improvement. Tuomey has investigated the currently available technologies and has identified viable solutions to improve the medication administration process. Bedside Medication Administration systems using barcode verification (BMV) and Computerized Physician Order Entry with Clinical Decision Support (CPOE/CDSS) have been identified as two systems that can greatly minimize the chance of errors and promote the highest quality care in the medication administration process.

Bedside Medication Administration using barcode identification systems have consistently been shown to improve patient safety and patient billing in hospital sites throughout the country. The basic process for bar code medication administration systems begins with an initial positive identification of a patient by the nursing staff. After the initial identification, the patient is given a wristband with an identifying bar code. From that point forward, the patient will be identified via a scan of the wristband's bar code. Before administering any medication or performing a treatment, the patient must be identified to the system via the scan. By first correctly identifying the patient to the system, the nurse then allows the system to double check the other four rights before the actual administration.

If a medication order has expired or been changed, the nurse is immediately alerted to avoid a possible medication error or Adverse Drug Event. The basic setup for the bar code medication administration system involves a laptop computer with a scanner linked to a hospital wireless network that runs the medication verification and patient billing systems. Accurate identification and correct order association assure patient safety and patient billing is accurately updated at the point of administration.

Computerized Practitioner Order Entry (CPOE) and Clinical Decision Support System (CDSS) implementation at Tuomey will virtually eliminate the chance of error in the deciphering of handwritten orders and eliminate any need for transcription all together since providers will be entering all medication and treatment orders directly into the information system with alerts and warnings regarding allergies, duplications and dangerous interactions readily available. If the orders are accurately entered and double checked for safety, then the bedside point of administration system will accurately ensure the correctly entered orders are carried out safely and accurately as intended by the ordering clinicians. Nurses will ensure that all five standards of medication administration are correct and accurate using barcodes identifying both the medication and the patient.

While Bedside Medication Verification and Computerized Practitioner Order Entry/Clinical Decision Support Systems are highly interdependent, staging of the implementations are vital to success. CPOE/CDSS cannot receive real-time feedback regarding medication administration without a Bedside Medication Verification system implemented and functioning. Likewise, Computerized Practitioner Order Entry (CPOE) and Clinical Decision Support System (CDSS) maturity lags behind Bedside Medication Verification due to the level of sophistication and logic design required. Any implementation strategy for Bedside Medication Verification and CPOE/CDSS at Tuomey Healthcare System must include plans to implement Bedside Medication Verification before moving to the other systems.

In fiscal year 2007, we hope that the subcommittee will support our request for funding of $1.5 million in order to implement a Bedside Medication Verification system that will be Phase I of this entire project. It is our belief that we will be highly successful in this project and could serve as a resource and site for other health care organizations to learn from in enhancing the safety of all patients.

As healthcare continues to evolve, so does Tuomey Healthcare System. We're here to anticipate the needs of the communities we serve, responding with proactive healthcare initiatives, such as the systems noted above. Our stable but consistent growth positions Tuomey as one of South Carolina's largest healthcare systems. Tuomey is committed to Sumter, and it shows in everything we do.

NATIONAL INSTITUTES OF HEALTH

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR CANCER RESEARCH (AACR)

The number of cancer deaths is falling and the number of cancer survivors is increasing each year. This remarkable progress has occurred because of the advances in cancer research, discovery, detection, prevention, and treatment made possible, in part, by a strong and steady level of funding and commitment by the Federal Government.

The National Cancer Program supports an incredible array of cancer research programs that shows great promise for benefit to patients with cancer. To sustain the research momentum that has been so carefully built up over the past decade—and to continue to give hope to those with cancer—the Congress must provide sufficient resources to preserve the scientific infrastructure and foster new discoveries.

The American Association for Cancer Research (AACR) stands ready to contribute its share to accelerate our progress against this devastating disease. The AACR joins with other leaders in the cancer community to call upon the Congress to take the following actions to enable these invaluable programs to continue their contributions to improving the lives of patients with cancer and other life-threatening diseases:

(1) Provide a 5 percent increase in funding for the National Institutes of Health to $29.75 billion for fiscal year 2007; and

(2) Provide a 5 percent increase in funding for the National Cancer Institute to $5.03 billion for fiscal year 2007.

Early this year, it was reported that the number of cancer deaths every year in the United States fell for the first time in more than 70 years. Coupled with the fact that observed cancer death rates from all cancers combined dropped 1.1 percent

each year from 1993 to 2002, these persistent declines in cancer mortality rates are evidence of the success of the National Cancer Program and its research, prevention, and treatment advances.

Among these advances are a series of new targeted cancer therapies that have evolved from a process of rational drug design based upon our expanded understanding of the genetic basis of disease. For example, Herceptin became the first targeted therapy for breast cancer in 1997—it is an injectable antibody that targets and blocks the function of HER2 protein when it is overproduced in the body, which leads to cancer. In 2001, Gleevec became the first approved kinase inhibitor for cancer, shutting down the BCR–ABL kinase that causes chronic myeloid leukemia. These discoveries have led to a half-dozen other more recent drug approvals that are based upon these and other novel mechanisms of action.

Exciting, life-saving scientific progress such as this will only continue if it is nurtured and sustained by an adequate level of Federal research investment. The American Association for Cancer Research (AACR) calls upon the President and the United States Congress to make the commitment to sustain this research momentum by increasing the appropriations for the National Institutes of Health (NIH) to $29.75 billion and the National Cancer Institute (NCI) to $5.03 billion for fiscal year 2007. Without such a commitment, promising research will be abandoned, new treatments may never come to fruition, and patients with cancer will lose the hope of enjoying a life beyond cancer.

The AACR stands ready to contribute its share to accelerate our progress against this devastating disease. As AACR approaches its Centennial Year in 2007, with more than 24,000 members, it is well positioned to foster and facilitate the scientific developments that will underpin our forward movement in basic, translational, and clinical cancer research. Through its five prestigious scientific journals—including Cancer Research, the most frequently cited cancer journal in the world—AACR rapidly disseminates cutting-edge, peer-reviewed findings throughout the medical research community. AACR's Annual Meeting attracts more than 16,000 scientists worldwide to cross-disciplinary sessions led by the world's leading experts. The AACR has been at the forefront of the art of anticancer drug development and the science of cancer prevention, and originated the annual International Conference on Cancer Prevention Research. Through these high quality scientific meetings, along with prestigious awards and research training programs and grants, the AACR utilizes a multilayered approach to stimulate and foster the best science that will lead to the conquest of cancer.

No single sector or entity alone can successfully tackle the complex set of diseases known as cancer. Academic scientists and clinicians have a large role to play in discovery and the translation of discoveries into standard clinical care. Biotechnology and pharmaceutical companies, with their vast research and development and manufacturing and distribution capabilities, are also essential for the smooth, efficient, and effective delivery of cancer medicines to hospitals and patients. Barriers or roadblocks in any aspect of the research, discovery, development, or delivery path will have an adverse impact on achieving the goal of conquering cancer and saving lives.

Central to this multisector effort is the National Cancer Program and the fundamental and foundational work of the National Cancer Institute. For 35 years, because of the National Cancer Act, the NCI has spearheaded the research efforts that have led to the declining mortality rates we are experiencing today. The strategies underlying the National Cancer Program have been developed by the NCI in close collaboration with the cancer community. Each year the Director of the NCI engages in an open and transparent priority-setting process to develop a plan and budget proposal for the following year. It is reviewed by the cancer community and published each fall as The Nation's Investment in Cancer Research: A Plan and Budget Proposal. It is the definitive guide to how the NCI is using its funds and how it plans to spend additional funds should they become available.

The scope and breadth of the activities in which the National Cancer Institute is engaged are truly remarkable. As the leader of the Nation's grand plan to attack cancer, the NCI must be provided with the resources necessary to carry out its mission on many different fronts and in many different ways. The five-year doubling of the budget of the NIH enabled the National Cancer Institute to begin to expand its activities into promising new areas that had been beyond its reach. However, since the completion of the budget doubling in 2003, negligible NCI budget increases (in the .5 to 2.6 percent range) and an actual hard budget cut in fiscal year 2006, have forced retrenchment and curtailing of some research.

Our Nation's current investment in the National Cancer Institute supports a broad range of scientific research, infrastructure, communications structure, and technological advances. The AACR strongly supports continued and increased in-

vestments in these key areas as the surest way to guarantee progress against cancer. In particular, the AACR urges that the NCI maintain its focus on:

—Research to understand the causes and mechanisms of cancer, including continued studies into the genetic, environmental, and lifestyle factors that contribute to cancer causation. This research includes population studies that identify cancer risks, studies of normal as well as abnormal biological functioning, and research on cellular and molecular mechanisms of cancer initiation, progression, and metastasis.

—Research on new approaches to prevent or delay the onset of cancer, including nutrition, vaccination, and chemoprevention. This research should continue its emphasis on behavioral factors that affect cancer risk—poor diet, lack of physical activity, sun exposure, and tobacco use—and strategies to change these behaviors.

—Research to improve early detection and diagnosis of cancer through the discovery and development of biomarkers and imaging techniques. This research includes using proteomic technologies to develop biomarker panels and anatomical and molecular imaging techniques to detect tumors and identify metastasis, as well as studying how patients accept and comply with cancer screening methods.

—Research to discover, develop, and evaluate therapeutics for destroying or controlling cancer cells and metastasis. These include localized therapies—such as surgery or radiotherapy; systemic therapies—such as chemotherapy or vaccines; molecularly targeted therapies (such as Herceptin and Gleevec) directed at specific tumors or tissues; and combinations which are often more effective than either therapy alone.

—Research to improve the quality of cancer care and the quality of life of cancer patients, including the development of ways to measure quality, the impact of aging on quality of care, health and lifestyle issues of cancer survivors, and the development and application of interventions to overcome cancer health disparities.

The National Cancer Institute carries out this vast research portfolio through a wide variety of different vehicles and mechanisms in its research infrastructure. The AACR strongly favors continued and increased support for these areas to optimize the return on research dollars. In particular, the AACR recommends that the National Cancer Institute continue to utilize the following successful multisector approaches to implementing the National Cancer Program:

—Extramural program supports independent scientists conducting research in universities, teaching hospitals, and other organizations outside the NIH. The largest portion of NCI research funds is devoted to this program. It supports a balanced portfolio of more than 7,000 research and training awards, as well as grants, cooperative agreements, and contracts with individual investigators, professional societies, and research institutions. Peer-reviewed research under this program includes genetic, epidemiological, behavioral, social, applied, and surveillance research, basic prevention science, cancer biomarkers, chemopreventive agent development, community oncology and prevention trials, early detection, nutrition science, organ system research, cancer diagnostics, imaging, drug development, and biometrics, among others.

Thousands of AACR member scientists participate in and depend upon support from the extramural program to advance their research goals. Investigator-initiated scientific research is the engine driving new discoveries and advances in cancer research and it must remain at the forefront of efforts to conquer this disease. Funding for this aspect of the National Cancer Program must be maintained at a sufficiently high level to promote and advance research progress.

—Training and Career Development to increase the number of scientists who specialize in the basic or clinical biomedical fields is a critical NCI function. Such investments foster the development of interdisciplinary teams and ensure a growing core of well trained investigators to focus on cancer.

—Partnerships, including with other agencies, pharmaceutical companies, academia, and a wide variety of other organizations, are essential to leverage the limited resources of the NCI. Interagency agreements with the Food and Drug Administration and the Centers for Medicare and Medicaid Services have been highly successful in expediting new drug development and coverage for new treatments. The Academic Public Private Partnership Program (AP4) supports a new way of accelerating drug discovery and development through multiple partnerships.

—Additional important means used by the National Cancer Institute to advance its cancer research agenda include Cancer Centers and Centers of Research Excellence at major academic and research institutions across the country; Net-

works and Consortia, such as the Early Detection Research Network; NCI-Supported Clinical Trials that involve more than 12,000 investigators; Cancer Surveillance through the voluminous data collected by the NCI Surveillance, Epidemiology, and End Results (SEER) program; Technology Development, including the cancer Biomedical Informatics Grid (caBIG) platform for sharing research data; and Communication, Education, and Dissemination of research progress directly to and for the benefit of the public and public health professionals.

Through this wide array of effective mechanisms, the National Cancer Institute seeks to implement the ambitious research goals of the National Cancer Program. Each facet of the strategy is important and generates synergies with other facets to accomplish more than the apparent sum of the parts. Cuts to cancer research funding jeopardize multiple facets of the strategy and have a direct adverse impact on patients by delaying or halting development of promising treatments.

To sustain the research momentum that has been so painstakingly built up over the past decade, the Congress must provide sufficient resources to preserve the current infrastructure and prevent its diminishment through inflation or other means. The American Association for Cancer Research and the cancer community, recognizing the many competing demands on the Federal budget, believe that, at a minimum, a 5 percent increase for the NIH and the NCI, to $29.75 billion and $5.03 billion respectively, will enable these valuable programs to continue in a strong, if not robust, way.

To make a quantum push forward with our efforts against cancer, the Director of the National Cancer Institute has identified, with significant communitywide input, at least five additional areas and opportunities that the NCI is poised to exploit if the resources become available. By investing in these new strategic initiatives (at an additional cost of less than $800 million) the Congress will clearly demonstrate its strong commitment to making the conquest of cancer a national priority and a goal that is within our reach. Several of these areas for strategic new investments to accelerate our progress against cancer include:

—Expand the Number of Cancer Centers to improve access for underserved populations and extend their outreach and collaboration capabilities.
—Reengineer Cancer Clinical Trials through implementation of the recommendations of the Clinical Trials Working Group.
—Link Science and Technology using a variety of new mechanisms and resources.
—Integrate Cancer Science and encourage interdisciplinary team science across the biomedical research community.

This Nation has the most sophisticated and highly developed biomedical research infrastructure in the world in the National Institutes of Health. A significant portion of that research investment is directed squarely at the cancer problem. Incredible progress has been made in understanding this disease and in devising cutting-edge approaches to preventing, controlling, and eliminating it. The pace of this research must be maintained to continue our record of advances that is leading to decreased mortality and improved patient care and outcomes.

The American Association for Cancer Research respectfully requests the Congress to support, at a minimum, a 5 percent funding increase for the National Institutes of Health (to $29.75 billion) and the National Cancer Institute (to $5.03 billion) to preserve the ability of these successful institutions to continue their groundbreaking work toward the conquest of cancer for the benefit of all of our citizens.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY

The American Association for Geriatric Psychiatry (AAGP) appreciates this opportunity to present its recommendations on issues related to fiscal year 2007 appropriations for mental health research and services. AAGP is a professional membership organization dedicated to promoting the mental health and well being of older Americans and improving the care of those with late-life mental disorders. AAGP's membership consists of approximately 2,000 geriatric psychiatrists as well as other health professionals who focus on the mental health problems faced by senior citizens.

AAGP appreciates the work this subcommittee has done in recent years in support of funding for research and services in the area of mental health and aging through the National Institutes of Health (NIH) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Although we generally agree with others in the mental health community about the importance of sustained and adequate Federal funding for mental health research and treatment, AAGP brings a unique perspective to these issues because of the elderly patient population served by our members.

AAGP recognizes the Federal budget constraints that the subcommittee must consider in making allocations. At the same time, it is important to note that research dollars and better trained professionals can help avert a crisis in the delivery of mental health care to the elderly in future generations when more efficient and effective therapies are identified through research. In fact, the New England Journal of Medicine has just published an important study, funded by NIMH, that suggests we can significantly decrease relapse rates in depression—which lead to more physician visits and hospitalizations—by continuing these patients for longer periods on antidepressant medication. In addition, studies of the IMPACT model for treating late-life depression suggest that effective treatment of depression in primary care reduces the cost of general health care in those settings.

Even as we note the important research being doing in the field, there are serious concerns, shared by AAGP and researchers, clinicians, and consumers that there exists a critical disparity between appropriations for research, training, and health services and the projected mental health needs of older Americans. This disparity is evident in the convergence of several key factors:

—demographic projections inform us that, with the aging of the U.S. population, there will be an unprecedented increase in the burden of mental illness among aging persons, especially among the baby boom generation;

—this growth in the proportion of older adults and the prevalence of mental illness is expected to have a major direct and indirect impact on general health service use and costs;

—despite the fact that effective treatment exists, the current mental health needs of many older adults remain unmet;

—the number of physicians being trained in geriatric mental health research and clinical care is insufficient to meet current needs, and this workforce shortfall is projected to become a crisis as the U.S. population ages over the next decade;

—a major gap exists between research, mental health care policy, and service delivery; and

—as funding for Federal health research has slowed across disciplines, the allocation of funds for research that focuses specifically on aging and mental health is disproportionately low, and woefully inadequate to deal with the impending crisis of mental health in older Americans.

In this context, it is important to note actions relating to late life mental health addressed by the White House Conference on Aging, which was convened by President Bush in December 2005. Recognizing the current health and mental health needs of older Americans and the challenges awaiting as the Baby Boom generation ages, delegates placed mental health and geriatric health professional training issues at the forefront by voting them among their top 10 resolutions.

DEMOGRAPHIC PROJECTIONS AND THE MENTAL DISORDERS OF AGING

With the baby boom generation nearing retirement, the number of older Americans with mental disorders is certain to increase in the future. By the year 2010, there will be approximately 40 million people in the United States over the age of 65. Over 20 percent of those people will experience mental health problems. A national crisis in geriatric mental health care is emerging and has received recent attention in the medical literature. Action must be taken now to avert serious problems in the near future. While many different types of mental and behavioral disorders can occur late in life, they are not an inevitable part of the aging process, and continued research holds the promise of improving the mental health and quality of life for older Americans.

The current number of health care practitioners, including physicians, who have training in geriatrics is inadequate. As the population ages, the number of older Americans experiencing mental problems will almost certainly increase. Since geriatric specialists are already in short supply, these demographic trends portend an intensifying shortage in the future. There must be a substantial public and private sector investment in geriatric education and training, with attention given to the importance of geriatric mental health needs. We will never have, nor will we need, a geriatric specialist for every older adult. However, without mainstreaming geriatrics into every aspect of medical school education and residency training, broad-based competence in geriatrics will never be achieved. There must be adequate funding to provide incentives to increase the number of academic geriatricians to train health professionals from a variety of disciplines, including geriatric medicine and geriatric psychiatry. This year's loss of all funding for geriatric health professions programs under Title VII of the Public Health Service Act is a stunning blow to this critical need, and AAGP urges the subcommittee to restore these programs.

Current and projected economic costs of mental disorders alone are staggering. It is estimated that total costs associated with the care of patients with Alzheimer's disease is over $100 billion per year in the United States. Psychiatric symptoms (including depression, agitation, and psychotic symptoms) affect 30 to 40 percent of people with Alzheimer's and are associated with increased hospitalization, nursing home placement, and family burden. These psychiatric symptoms, associated with Alzheimer's disease, can increase the cost of treating these patients by more than 20 percent. Although NIA has supported extensive research on the cause and treatment of Alzheimer's, treatment of these behavioral and psychiatric symptoms has been neglected and should be supported through NIMH.

Depression is another example of a common problem among older persons. Of the approximately 32 million Americans who have attained age 65, about 5 million suffer from depression, resulting in increased disability, general health care utilization, and increased risk of suicide. Depression is associated with poorer health outcomes and higher health care costs. Co-morbid depression with other medical conditions affects a greater use and cost of medications as well as increased use of health services (e.g., medical outpatient visits, emergency visits, and hospitalizations). For example, individuals with depression are admitted to the emergency room for hypertension, arthritis, and ulcers at nearly twice the rate of those without depression. Those individuals with depression are more likely to be hospitalized for hypertension, arthritis, and ulcers than those without depression. And, those with depression experience almost twice the number of medical visits for hypertension, arthritis and ulcers than those without depression. Finally, the cost of prescriptions and number of prescriptions for hypertension, arthritis, and ulcers were more than twice than those without depression.

Older adults have the highest rate of suicide rate compared to any other age group. Comprising only 13 percent of the U.S. population, individuals age 65 and older account for 19 percent of all suicides. The suicide rate for those 85 and older is twice the national average. More than half of older persons who commit suicide visited their primary care physician in the prior month—a truly stunning statistic.

NATIONAL INSTITUTE OF MENTAL HEALTH

In his fiscal year 2007 budget, the President proposed a decrease in funding for the National Institutes of Health (NIH), for the first time in 30 years. This decline in funding is likely to have a devastating impact on the ability of NIH to sustain the ongoing, multi-year research grants that have been initiated in recent years.

AAGP would like to call to the subcommittee's attention the fact that, even in the years in which funding was increased for NIH and NIMH, these increases did not always translate into comparable increases in funding that specifically address problems of older adults. Data supplied to AAGP by NIMH indicates that while extramural research grants by NIMH increased 59 percent during the five-year period from fiscal year 1995 through fiscal year 2000 (from $485,140,000 in fiscal year 1995 to $771,765,000 in fiscal year 2000), NIMH grants for aging research increased at less than half that rate: only 27.2 percent during the same period (from $46,989,000 to $59,771,000). Furthermore, despite the fact that over the past 5 years, Congress, through committee report language, has specifically urged NIMH to increase research grant funding devoted to older adults, this has not occurred.

AAGP is pleased that NIMH has recently renewed its emphasis on mental disorders among the elderly, and commends the recent creation of a new Aging Treatment and Prevention Intervention Research Branch at NIMH. AAGP would like the scope of this Branch increased into a comprehensive aging Branch that is responsible for all facets of clinical research, including translational, interventions, and disease-based psychopathology. The Branch should also be given adequate resources to fulfill its primary mission within NIMH.

In addition to supporting research activities at NIMH, AAGP supports increased funding for research related to geriatric mental health at the other institutes of NIH that address issues relevant to mental health and aging, including the National Institute of Aging (NIA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute on Drug Abuse (NIDA), and the National Institute of Neurological Disorders and Stroke.

CENTER FOR MENTAL HEALTH SERVICES

It is also critical that there be adequate funding for the mental health initiatives under the jurisdiction of the Center for Mental Health Services (CMHS) within SAMHSA. While research is of critical importance to a better future, the patients of today must also receive appropriate treatment for their mental health problems. SAMHSA provides funding to State and local mental health departments, which in

turn provide community-based mental health services to Americans of all ages, without regard to the ability to pay. AAGP was pleased that the final budgets for the last 5 years have included $5 million for evidence-based mental health outreach and treatment to the elderly. AAGP worked with members of this subcommittee and its House counterpart on this initiative, which is a very important program for addressing the mental health needs of the Nation's senior citizens. Increasing this mental health outreach and treatment program must be a top priority, as it is the only Federally funded services program dedicated specifically to the mental health care of older adults.

The greatest challenge for the future of mental health care for older Americans is to bridge the gap between scientific knowledge and clinical practice in the community, and to translate research into patient care. Adequate funding for this geriatric mental health services initiative is essential to disseminate and implement evidence-based practices in routine clinical settings across the States. Consequently, we would urge that the $5 million for mental health outreach and treatment for the elderly included in the CMHS budget for fiscal year 2005 be increased to $20 million for fiscal year 2006. Of that $20 million appropriation, AAGP believes that $10 million should be allocated to a National Evidence-Based Practices Program, which will disseminate and implement evidence-based mental health practices for older persons in usual care settings in the community. This program will provide the foundation for a longer-term national effort that will have a direct effect on the well-being and mental health of older Americans.

The Community Mental Health Services Block Grant Program requires States and territories to include an annual plan for providing comprehensive community mental health services to adults with a serious mental illness and children with a serious emotional disturbance. Experience has demonstrated that States do not make adequate provisions for older adults. AAGP recommends that SAMHSA require these plans to include specific provisions for mental health services for older adults.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

Despite growing evidence of the need for more geriatric specialists to care for the nation's elderly population, a critical shortage persists. For fiscal year 2006, the Congress inexplicably eliminated all funding for the geriatric health professions program under Title VII of the Public Health Service Act. The loss of these programs could have a disastrous impact on physician workforce development over the next decade, with dangerous consequences for the growing population of older adults who will not have access to appropriate specialized care. The geriatric health professions program supports three important initiatives. The Geriatric Faculty Fellowship trains faculty in geriatric medicine, dentistry, and psychiatry. The Geriatric Academic Career Award program encourages newly trained geriatric specialists to move into academic medicine. The Geriatric Education Center (GEC) program provides grants to support collaborative arrangements that provide training in the diagnosis, treatment, and prevention of disease. In fiscal year 2005, these programs were funded at $31.5 million, but, while they were funded in the Senate Appropriations bill for fiscal year 2006, the final legislation followed the House version, which eliminated funding for them. AAGP urges the subcommittee to restore funding to this program at fiscal year 2005 levels.

The loss of these programs, just as the massive Baby Boomer generation are entering late life, will have a devastating effect on the Nation's ability to provide the kind of health care that will allow these seniors to be independent and productive as they age.

CONCLUSION

Based on AAGP's assessment of the current need and future challenges of late life mental disorders, we submit the following fiscal year 2007 funding recommendations:

1. The current rate of funding for aging grants at NIMH and CMHS is inadequate and should be increased to at least three times their current funding levels. In addition, the substantial projected increase in mental disorders in our aging population should be reflected in the budget process in terms of dollar amount of grants and absolute number of new grants.

2. To help the country's elderly access necessary mental health care, previous years' funding of $5 million for evidence-based mental health outreach and treatment for the elderly within CMHS must be increased to $20 million.

3. Funding for the geriatric health professions program under Title VII of the Public Health Service Act should be restored to fiscal year 2005 levels.

4. Both NIMH and CMHS must support adequate infrastructure and funding within both NIMH and CMHS to develop initiatives in aging research, to monitor the number and quality of applicants for aging research grants, to promote funding of meritorious projects, and to manage those grant portfolios.

5. The scope of the recently formed Aging Treatment and Prevention Intervention Research Branch at NIMH should be increased to include all relevant clinical research, including translational, interventions, and disease-based psychopathology, and must receive NIMH's full support so it may fulfill its primary mission.

AAGP looks forward to working with the members of this subcommittee and others in Congress to establish geriatric mental health research and services as a priority at appropriate agencies within the Department of Health and Human Services.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF IMMUNOLOGISTS

The American Association of Immunologists ("AAI") is pleased to have this opportunity to submit its views on fiscal year 2007 funding for the National Institutes of Health (NIH). AAI would like to thank the members of the subcommittee for their strong support for biomedical research, and in particular, express our great appreciation to the chairman, Senator Specter, and Ranking Member, Senator Harkin, for their extraordinary leadership and dedication to advancing biomedical research.

The AAI is a not-for profit professional society representing more than 6,500 research scientists and physicians who are the world's leading experts on the immune system. While our members work in academia, government, and industry, most are among the more than 200,000 research personnel affiliated with more than 3,000 institutions who depend on NIH funding to support their work.[1] With approximately 84 percent of NIH funds awarded to these individuals and institutions, NIH's funding level has a huge impact both on the advancement of biomedical research and on the local, State, and national economies.

THE IMPORTANCE OF IMMUNOLOGY

Immunological research is crucial in a world increasingly at risk from infectious agents and chronic diseases.[2] Basic research on the immune system provides a foundation for the development of diagnostics, vaccines, and therapeutics. Current efforts are focused on preventing and treating diseases caused by natural infectious agents, including influenza and avian flu, SARS, West Nile Virus, tuberculosis, and AIDS, as well as those that may be modified for use as agents of bioterrorism, including plague, smallpox, and anthrax. In addition, basic immunological research continues to be crucial in the development of increasingly effective approaches for treating chronic diseases, including cancer, autoimmune diseases, inflammatory disorders, and immunodeficiencies.

The immune system works by recognizing and attacking "foreign invaders" (i.e., bacteria and viruses) inside the body. It also plays an important role in controlling the growth of tumor cells. The immune system can protect its host (human or animal) from illness or disease either entirely—by attacking and destroying the virus, bacterium, or tumor cell—or partially, resulting in a less serious illness. But even a healthy immune system cannot completely protect us from all threats that might cause disease. Moreover, the immune system also has a "dark side": it can lead to the rejection of transplanted organs or bone marrow and—if it is working improperly—can allow the body to attack itself instead of an invader, resulting in an "autoimmune" disease (e.g., Type 1 diabetes, multiple sclerosis, rheumatoid arthritis).

Recent advances in immunology have allowed for revolutionary treatments. For example, therapeutic substances called "biologics" have provided new, effective treatments for painful, debilitating and life-threatening diseases such as rheumatoid

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[1] National Institutes of Health Fiscal Year 2007 Performance Budget Overview, pp.1–2. Many AAI members are medical school professors and researchers who receive grants from NIH, and in particular from the National Institute of Allergy and Infectious Diseases (NIAID) and the National Cancer Institute (NCI) (as well as other NIH Institutes and Centers), to support their research endeavors.

[2] Immunologists depend heavily on the use of animal models in their research. Without animal experimentation, theories about immune system function and treatments that might cure or prevent disease would have to be tested first on human subjects, something our society—and our scientists—would never countenance. Despite the clear necessity for animal research, we are experiencing both increasing regulatory burden in animal experimentation (eroding the return on NIH's investment), and threats from people and organizations that oppose such research. The legal and illegal methods used by some groups to further an animal-rights/anti-medical research agenda are diverting precious resources from our work, threatening the personal safety and security of scientists, and delaying the progress of important research now underway.

arthritis, inflammatory diseases, and cancer. Biologics that use modified human antibodies and cell receptors specifically target the substance (TNF) that causes joint destruction in rheumatoid arthritis, and the painful symptoms of psoriasis, and ankylosing spondylitis. An engineered antibody (herceptin) is being used to control the reoccurrence of breast cancer; resulting in a two-fold reduction in reoccurrence. Another monoclonal antibody and human protein—CTLA4Ig—has been dramatically effective in clinical trials treating prostate cancer and melanoma as well as showing promise as a treatment for lupus, arthritis, multiple sclerosis, and organ transplant rejection.

Immunologists have also focused on improved approaches to vaccine development, including a vaccine for *Hemophilius influenza* type b. This vaccine has reduced the incidence of pediatric meningitis in the United States from approximately 20,000 to 200 cases per year. Our understanding of what makes an efficacious vaccine will be critical as we face future pandemics, be they natural, like avian flu, or altered pathogens that could be used for bioterrorism, like missilized anthrax.

None of these advances could have been made without substantial public investment in basic immunological research. But even as we make huge strides, new threats emerge: immunologists are working feverishly to defend against bird flu and potential bioterrorism pathogens.

THE NIH BUDGET: TROUBLE IN THE POST-DOUBLING YEARS

AAI is very grateful to this subcommittee and the Congress for doubling the NIH budget from fiscal year 1998 to fiscal year 2003. This "doubling" represented an unprecedented commitment by the Federal Government to preventing, treating, and curing disease, and has allowed scientists to begin new, cutting edge research made possible by recent advances in sequencing the genomes of humans, model organisms, and microbial pathogens that cause human and animal diseases.

But scientific research takes time, and the doubling of the NIH budget will have been for naught if we are unable to complete ongoing studies or retain trained personnel. Indeed, the doubling has already been eroded. Since 2003, the annual increases in the NIH budget have not kept pace with biomedical research inflation.[3] Moreover, the President's fiscal year 2007 "flat" budget would result in an effective decrease in the NIH budget, only the second time in 36 years that the NIH budget has been reduced. This would have a devastating effect:

1. Key NIH Institutes could be forced to drop paylines even lower than the current, far too low 10–14 percent (significantly below the approximately 22 percent funded during the doubling);[4]

2. There would be no inflationary increases for direct, recurring costs in non-competing Research Project Grants (RPGs), undermining NIH's fiscal year 2007 goal to "preserve to the greatest extent possible the ability of scientists to obtain individual support for their research ideas." National Institutes of Health Summary of the Fiscal Year 2007 President's Budget February 6, 2006, p.3;

3. It would have rapid, adverse repercussions on the future of the research enterprise. Our brightest young people will be deterred from pursuing biomedical research careers if their chances of receiving an NIH grant become even lower. If we cannot attract and retain the best young minds, the United States will lose its preeminence in science and technology to nations—including India, Singapore, China, and Korea—that are investing aggressively to compete.

4. It would not permit increases in already inadequate stipends to pre- and postdoctoral fellows, and will undermine efforts to attract excellent scientists to NIH and to academia.

PANDEMIC INFLUENZA/INFLUENZA

Influenza leads to more than 200,000 hospitalizations and about 36,000 deaths nationwide in an average year. Pandemic influenza could cause millions of deaths and hospitalizations. Despite these very real threats, the President's fiscal year 2007 NIH Budget includes an increase of only $17 million to support specific re-

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[3] NIH funding increases/decreases since the doubling period ended [fiscal year 2004 (3.03 percent), fiscal year 2005 (2.18 percent) and fiscal year 2006 (−.12 percent)] have all been below the Biomedical Research and Development Price Index ("BRDPI"), a U.S. Department of Commerce ("DOC") estimate of the cost of inflation for biomedical research. The BRDPI was developed by the DOC's Bureau of Economic Analysis under an agreement with NIH and is updated annually. It indicates how much the NIH budget must increase to maintain purchasing power. Projections for future years are prepared by the NIH Office of Science Policy.

[4] AAI analyzed paylines of key NIH Institutes from fiscal year 2000-fiscal year 2002; see www.nih.gov.

search initiatives focused on pandemic influenza, bringing total NIH spending on influenza to approximately $199 million (about $35 million over fiscal year 2006).

The vast majority of funds (more than $3 billion) appropriated to date under the Department of Health and Human Services Pandemic Influenza Preparedness Plan have been devoted to other pandemic influenza related activities (including production/procurement of vaccines/antivirals). While these public health efforts are extremely important, it is essential to realize that any existing pathogen that could cause influenza or pandemic influenza (e.g., bird flu) can mutate, rendering existing countermeasures ineffective. Since new influenza strains can quickly emerge, research to identify new pathogens, understand the immune response, and develop tools for protecting against the pathogen should never take a back seat to other pandemic influenza-related activities. The need for this research supports AAI's request for an increased budget for NIH.

BIODEFENSE RESEARCH

AAI supports the President's request for $1.891 billion for biodefense research, an increase of 6.2 percent over fiscal year 2006. NIH's fiscal year 2007 biodefense research priorities include continuing work on developing vaccines and treatments for anthrax, smallpox, plague, tularemia, hemorrhagic fevers, and botulinum toxin.

NIH plans to direct $160 million to an Advanced Development Fund ("ADF") within the Office of the NIH Director to "support efforts to work with academia and industry to develop candidate countermeasures from the point of Investigation New Drug Application (INDA) to the level that these candidate countermeasures could be eligible for acquisition by Project Bioshield." AAI urges that the NIH Director work closely with the NIAID Director to ensure that the ADF focuses on NIH's traditional expertise in basic and translational research and not on activities relevant to commercial development or the manufacturing of a product.

NIH also plans to spend $25 million to construct additional high containment laboratories at biosafety level (BSL) 3 and to renovate existing labs to meet current BSL–3 standards. (BSL–3 labs are necessary for the safe conduct of research on dangerous and infectious pathogens.) AAI recommends that these funds be used first for the renovation of existing labs; the construction of new labs may not be necessary with the limited research funding that may be available this year.

ADMINISTRATIVE ISSUES

1. Office of Portfolio Analysis and Strategic Initiatives

AAI supports the newly formed Office of Portfolio Analysis and Strategic Initiatives (OPASI) as a way of better managing and analyzing NIH's portfolio. While we understand the need for a "Common Fund" to support OPASI, we believe that, in this difficult fiscal climate, such a fund should be limited and should grow no faster than the overall NIH budget.

2. Research, Management and Support (RM&S)

The President's fiscal year 2007 budget proposal for Research, Management and Services (RM&S), which supports the management, monitoring, and oversight of intramural and extramural research activities (including NIH's highly regarded peer review process), includes an increase of $14 million, or 1.3 percent. AAI supports an appropriate increase in the RM&S budget to ensure that it is sufficient (1) to enable NIH to supervise a portfolio of increasing size and complexity and (2) to ensure that NIH funds are well and properly spent.

3. Outsourcing

AAI continues to be concerned about the "outsourcing" of NIH jobs. While certain NIH jobs may be appropriate for such an approach, it should not be applied to program administration staff, many of whom are highly experienced and have historical knowledge and understanding of NIH programs and policies. Such outsourcing would result in the loss of a dedicated and capable workforce and reduce efficiency in the long run.

AAI'S RECOMMENDED BUDGET INCREASE FOR FISCAL YEAR 2007: 5 PERCENT (1.2 PERCENT ABOVE PROJECTED INFLATION)

AAI strongly believes that we must increase the NIH budget now in order to capitalize on important advances that have resulted from the doubling. We urge this subcommittee to increase the NIH budget by 5 percent ($1.4 billion) in fiscal year 2007, for a total budget of $29.75 billion. This increase, which is only 1.2 percent above the projected rate of biomedical research inflation, would enable researchers to capitalize on important advances that have resulted from the doubling, leading

to increased translational and clinical applications. It would also assist efforts to attract and retain bright young American scientists to research careers.

THE EFFECTIVE USE OF NIH FUNDS

While AAI advocates a 5 percent increase in NIH funding, we agree that NIH should use its existing funds as effectively as possible. To that end, we recommend the following:

(1) The "NIH Roadmap for Biomedical Research" ("NIH Roadmap")

AAI notes that the President's fiscal year 2007 budget request for the NIH Roadmap has grown to $443 million, an increase of $113 million over fiscal year 2006. While AAI supports this effort to fund multidisciplinary, interdisciplinary research and agrees that such research is an important part of biomedical research in the 21st century, we recommend that funds allocated to the NIH Roadmap not grow faster than the overall NIH budget and that all Roadmap funds, including the Director's Pioneer Awards, be awarded through a rigorous peer review process.

(2) NIH "Enhanced Access to Scientific Publications" Policy

AAI recommends that NIH partner with not-for-profit scientific publishers to provide enhanced public access to NIH-funded research results, rather than continuing an expensive effort to publish manuscripts itself. In this era of limited funds, NIH should work with these willing partners to ensure that its budget is used to support and advance research and not to duplicate services already provided by the private sector. AAI urges the subcommittee to support efforts underway between NIH and the not-for-profit scientific publishing community to develop a policy that will enhance public access while addressing the concerns of publishers.

(3) Peer review and the independence of science

Millions of lives—as well as the prudent use of taxpayer dollars—depend on government officials receiving—and taking—the very best and most independent scientific advice available. We urge this subcommittee to provide oversight which ensures that funds expended enhance the ability of scientists to provide independent scientific advice (particularly on government scientific advisory panels) and preserve independent peer review (including ensuring the review of scientific research results by peers through robust, independent scientific journals).

CONCLUSION

AAI greatly appreciates this opportunity to testify and thanks the members of this subcommittee for your strong support for biomedical research, the NIH, and the scientists who devote their lives to preventing, treating, and curing disease. We look forward to working with you and hope that you will contact me or AAI if you have any questions or if we can be of assistance.

PREPARED STATEMENT OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

FISCAL YEAR 2007 APPROPRIATIONS REQUEST SUMMARY

	Fiscal year 2006 actual	Fiscal year 2007 budget	AANA fiscal year 2007 request
HHS/HRSA/BHPr Title VIII Advanced Education Nursing, Nurse Anesthetist Education Reserve.	Awaiting grant allocations. $3.5 million fiscal year 2005.	Grant allocations not specified.	$4 million for nurse anesthesia education $65 million for advanced education nursing
Title VIII HRSA BHPr Nursing Education Programs	$151,191,000	$150,000,000	$175,000,000

The AANA is the professional association for more than 34,000 Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists representing over 90 percent of the nurse anesthetists in the United States. Today, CRNAs are directly involved in approximately 65 percent of all anesthetics given to patients each year in the United States. CRNA services include administering the anesthetic, monitoring the patient's vital signs, staying with the patient throughout the surgery, as well as providing acute and chronic pain management services. CRNAs provide anesthesia for a wide variety of surgical cases and are the sole anesthesia providers in almost 70 percent of rural hospitals, affording these medical facilities ob-

stetrical, surgical, and trauma stabilization, and pain management capabilities. CRNAs work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers (ASCs), pain management units and the offices of dentists, podiatrists and plastic surgeons.

Nurse anesthetists are experienced and highly trained anesthesia professionals whose record of patient safety in the field of anesthesia was bolstered by the Institute of Medicine report that found in 2000, that anesthesia is 50 times safer than 20 years previous. (Kohn L., Corrigan J., Donaldson M., ed. To Err is Human. Institute of Medicine, National Academy Press, Washington DC, 2000.) Nurse anesthetists continue to set for themselves the most rigorous continuing education and re-certification requirements in the field of anesthesia. Relative anesthesia patient safety outcomes are comparable among nurse anesthetists and anesthesiologists, with Pine having recently concluded, "the type of anesthesia provider does not affect inpatient surgical mortality." (Pine, Michael MD et al. Surgical mortality and type of anesthesia provider. Journal of American Association of Nurse Anesthetists. Vol. 71, No. 2, p. 109–116. April 2003.) In addition, a recent AANA workforce study's data showed that CRNAs and anesthesiologists are substitutes in the production of surgeries. Through continual improvements in research, education, and practice, nurse anesthetists are vigilant in their efforts to ensure patient safety.

CRNAs provide the lion's share of the anesthesia care required by our U.S. Armed Forces through active duty and the reserves, from here at home to the leading edge of the field of battle. In May 2003, at the beginning of "Operation Iraqi Freedom" 364 CRNAs were deployed to the Middle East to ensure military medical readiness capabilities. For decades, CRNAs have staffed ships, remote U.S. military bases, and forward surgical teams without physician anesthesiologist support.

IMPORTANCE OF TITLE VIII NURSE ANESTHESIA EDUCATION FUNDING

The nurse anesthesia profession's chief request of the subcommittee is for $4 million to be reserved for nurse anesthesia education and $65 million for advanced education nursing from the Title VIII program. This sustained funding is justified by two facts. First, there is a 12 percent vacancy rate of nurse anesthetists in the United States impacting people's healthcare. And second, the Title VIII program, which has been strongly supported by members of this subcommittee in the past, is an effective means to help address the nurse anesthesia workforce demand. This demand for CRNAs is something that the nurse anesthesia profession addresses every day with success, and with the critical assistance of Federal funding through HHS' Title VIII appropriation.

The increase in funding for advanced education nursing from $58 million to $65 million is necessary to meet the continuing demand for nursing faculty and other advanced education nursing services throughout the United States. Only a limited number of new programs and traineeships can be funded each year at the current funding levels. The program provides for competitive grants and contracts to meet the costs of projects that support the enhancement of advanced nursing education and practice and traineeships for individuals in advanced nursing education programs. This funding is critical to the efforts to meet the nursing workforce needs of Americans who need healthcare.

In 2003, the AANA conducted a nurse anesthesia workforce study that concluded a 12 percent vacancy rate in hospitals for CRNAs, and a lower vacancy rate in ambulatory surgical centers. The supply has increased in recent years, stimulated by increases in the number of CRNAs trained. However, these increases had not been enough to offset the number of retiring CRNAs. This trend, established in 2003, requires a continuous growth in the number of nurse anesthesia graduates to fill the vacancy rate. This is compounded by the rising number of Medicare-eligible Americans, from about 34 million today to more than 40 million in 2010, who will require the care that CRNAs provide.

The problem is not that our 99 accredited programs of nurse anesthesia are failing to attract qualified applicants; it is that the programs are full. Each CRNA program continues to turn away qualified applicants—bachelor's educated registered nurses who had spent at least 1 year serving in an acute care environment. These CRNA schools are located all across the country including the following:

State	Number of accredited nurse anesthesia programs
PA	12
FL	6
OH	5

State	Number of accredited nurse anesthesia programs
TX	5
IL	4
NY	4
CA	3
CT	3
MD	3
RI	2
WI	1

Recognizing the importance of nurse anesthetists to quality healthcare, the AANA has been working with the 99 accredited programs of nurse anesthesia to increase the number of qualified graduates. In addition, the AANA has worked with nursing and allied health deans to develop new CRNA programs.

The Council on Certification of Nurse Anesthetists (CCNA) reports that in 1999, our schools produced 948 new graduates. In 2005, that number had increased to 1,790, an 89 percent increase in just 5 years. This growth is expected to continue. The CCNA projects CRNA programs to produce over 1,900 graduates in 2006.

To truly meet the nurse anesthesia workforce challenge, the capacity and number of CRNA schools must continue to expand. With the help of competitively awarded grants supported by Title VIII funding, the nurse anesthesia profession is making significant progress, expanding both the number of clinical practice sites and the number of graduates.

The AANA is pleased to report that this progress is extremely cost-effective from the standpoint of Federal funding. Anesthesia can be provided by nurse anesthetists, physician anesthesiologists, or by CRNAs and anesthesiologists working together. As mentioned earlier, it has been confirmed, "the type of anesthesia provider does not affect inpatient surgical mortality." Yet, for what it costs to train just one anesthesiologist, several CRNAs may be educated to provide the same service with the same optimum level of safety. This represents a significant educational cost/benefit for supporting CRNA educational programs with Federal dollars vs. supporting other models of anesthesia education.

To further demonstrate the effectiveness of the $3 million Title VIII investment in nurse anesthesia education, the AANA surveyed its CRNA program directors in 2003 to gauge the impact of the Title VIII funding. Of the eleven schools that had reported receiving competitive Title VIII Nurse Education and Practice Grants funding from 1998 to 2003, the programs indicated an average increase of at least 15 CRNAs graduated per year. They also reported on average more than doubling their number of graduates, who provide care to patients during and following their education. Moreover, they reported producing additional CRNAs that went to serve in rural or medically underserved areas. Under both of these circumstances, an increased number of student nurse anesthetists and CRNAs are providing healthcare to the people of medically underserved America.

We believe it is important for the subcommittee to allocate $4 million for nurse anesthesia education for several reasons. First, as this testimony has documented, the funding is cost-effective and well needed. Second, the Title VIII authorization previously providing such a reserve expired in September 2002. Third, this particular funding is important because nurse anesthesia for rural and medically underserved America is not affected by increases in the budget for the National Health Service Corps and community health centers, since those initiatives are for delivering primary and not surgical healthcare. Lastly, this funding meets an overall objective to increase access to quality healthcare in medically underserved America.

TITLE VIII FUNDING FOR STRENGTHENING THE NURSING WORKFORCE

The AANA joins a growing coalition of nursing organizations and others in support of the subcommittee providing a total of $175 million in fiscal year 2007 for nursing shortage relief through Title VIII. This amount is approximately $25 million over the fiscal year 2005 level and over the President's fiscal year 2007 budget.

Every district in America is familiar with the importance of nursing. The AANA is appreciative of the leadership of the subcommittee and the congressional support for the $5 million increase over the President's request in fiscal year 2005 for nurse education funding.

America spends more than $2 trillion on healthcare this year, paid by private and public sources. About $298 billion accounted for Medicare outlays in 2005. Medicare directs about $8.7 billion of that to fund direct and indirect GME, with some 99 per-

cent of that funding helping to educate physicians and allied health professionals, and about 1 percent to help educate nurses. For every present and future healthcare patient, Congress must put some focus on nurses and nurse anesthesia care.

To ensure that America has access to nurse anesthesia care when needed, a sustained investment from Congress is necessary especially for the provision of services in rural and medically underserved America. Quality anesthesia care provided by CRNAs saves lives, promotes quality of life, and makes fiscal sense. This Federal support for nurse education will improve patient access to quality services and strengthen the Nation's healthcare delivery system.

Thank you.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF CARDIOLOGY

The American College of Cardiology appreciates the opportunity to provide the subcommittee with recommendations for fiscal year 2007 funding for life-saving cardiovascular research and education.

The ACC is a 33,000 member non-profit professional medical society and teaching institution whose purpose is to foster optimal cardiovascular care and disease prevention through professional education, promotion of research, and leadership in the development of standards and formulation of health care policy.

Heart disease is the leading cause of death for both women and men in the United States, killing more than 900,000 Americans each year. More than 70 million Americans live with some form of heart disease. The economic impact of cardiovascular disease on the U.S. health care system continues to grow as the population ages. In 2005, heart disease and stroke were projected to cost the Nation $393 billion, including health care services, medications, and lost productivity.

As the premier cardiovascular society, the ACC supports a strong Federal investment in research and public education that addresses the prevention, detection and treatment of cardiovascular disease. Current Federal research is providing breakthrough advances that fundamentally change our understanding of cardiovascular disease, leading to more effective treatments, decreased costs and increased quality of life for patients.

For instance, a study published in the February 2006 issue of the Journal of the American College of Cardiology yielded important findings for women with coronary heart disease. Part of the National Heart, Lung, and Blood Institute (NHLBI)'s Women's Ischemia Syndrome Evaluation (WISE) study, researchers found that women with a condition called coronary microvascular syndrome often go undiagnosed for heart disease because dysfunction occurs in very small arteries of the heart and does not show up when physicians use standard tests. As a result of the missed diagnosis, women are not treated for angina and high cholesterol and remain at high risk for a heart attack. National Institutes of Health (NIH) studies like WISE are helping to unravel the mystery of cardiovascular disease in women and hold immediate implications for the treatment of women at risk for heart disease.

The ACC is extremely concerned that the administration's budget request proposes no increase in funding for the NIH and cuts funding for many critical health programs. If instituted, the administration's budget would force the research community to scale back and even halt valuable initiatives. The ACC is encouraged that the Senate recently approved an amendment to its budget resolution that provides an extra $7 billion for key health and education programs.

FUNDING RECOMMENDATIONS

The ACC urges Congress to support the following fiscal year 2007 funding recommendations.

National Institutes of Health: $29.849 billion.—Research conducted through the NIH has resulted in better diagnosis and treatment of cardiovascular disease, improving the quality of life for those living with the disease and lowering the number of deaths attributed to it.

National Heart Lung and Blood Institute: $3.068 billion.—The NIH is doing critical research into the causes, treatment and prevention of cardiovascular disease through the NHLBI.

Agency for Healthcare Research and Quality: $440 million.—The Agency for Healthcare Research and Quality (AHRQ)'s health services research complements the research of the NIH by helping cardiologists make choices about what treatments work best, for whom and when.

CDC State Heart Disease and Stroke Prevention Program: $55 million.—The Centers for Disease Control and Prevention (CDC) State Heart Disease and Stroke Pre-

vention program's public education efforts is making strides in the prevention and early intervention of cardiovascular disease.

HRSA Rural and Community AED Program: $9 million.—The Health Resources and Services Administration (HRSA) Rural and Community Access to Emergency Defibrillation program is saving lives by placing external defibrillators in public facilities.

SUMMARY

The ACC appreciates the subcommittee's past support for these important programs. The ACC urges Congress to provide a strong fiscal year 2007 investment in the cardiovascular research and education programs described above to continue the great strides being made in fighting cardiovascular disease. Should you have any questions, please contact Jennifer Brunelle at jbrunell@acc.org or (301) 581–3477.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists (ACOG), representing 49,000 physicians and partners in women's health care, is pleased to offer this statement to the House Committee on Appropriations, Subcommittee on Labor, Health and Human Services, and Education. We thank Chairman Regula, Ranking Member Obey, and the entire subcommittee for their leadership to continually address maternal and child health care services.

The Nation has made important strides to improve women and children's health over the past several years, and ACOG is grateful to this Committee for its commitment to research. We look forward to working with the Members of this Committee to ensure that vital research continues to eliminate disease and to ensure valuable new treatment discoveries are implemented. The National Institutes of Health (NIH) has examined and determined many disease pathways, while the Health Resources and Services Administration (HRSA) and the Centers for Disease Control and Prevention (CDC) have been successful in translating research findings into valuable public health policy solutions. This dedicated commitment to elevate, promote and implement medical research faces an uncertain future at a time when scientists are on the cusp of new cures.

It is essential that the Committee provide strong support for current studies, and for future advances, as well. We urge the Committee to support a an fiscal year 2007 appropriation of $29.75 billion for the NIH, and $1.328 billion for the National Institute of Child Health and Human Development (NICHD), both a 5 percent increase over fiscal year 2006 levels. We also continue to support efforts to secure adequate funds for important public health programs at HRSA ($7.5 billion) and the CDC ($8.5 billion plus funding for pandemic influenza preparedness).Continued appropriations to these agencies will ensure ongoing and new research initiatives continue to yield positive results for women and children's health.

NATIONAL INSTITUTES OF HEALTH—RESEARCH LEADING THE WAY

Research at the NICHD

The NICHD conducts research that holds great promise to improve maternal and fetal health and safety. With the support of Congress, the Institute has initiated research addressing the causes of cerebral palsy, gestational diabetes and pre-term birth. However, much more needs to be done to reduce the rates of maternal mortality and morbidity in the United States. More research is needed on such pregnancy-related issues as the impact of chronic conditions during pregnancy, racial and ethnic disparities in maternal mortality and morbidity, and drug safety with respect to pregnancy.

A commitment to research in maternal health sheds light on a breadth of issues that save women's lives. Important research examining the following issues must continue:

Reducing High Risk Pregnancies

NICHD's Maternal Fetal Medicine Unit Network, working at 14 sites across the United States (University of Alabama, University of Texas-Houston, University of Texas-Southwestern, Wake Forest University, University of North Carolina, Brown University-Women and Infant's Hospital, Columbia University, Drexel University, University of Pittsburgh-Magee Women's Hospital, University of Utah, Northwestern University, Wayne State University, Case Western University, and Ohio State University), will help reduce the risks of cerebral palsy, caesarean deliveries,

and gestational diabetes. This Network discovered that progesterone reduces preterm birth by one-third.

Reducing the Risk of Perinatal HIV Transmission

In the last 10 years, NICHD research has helped decrease the rate of perinatal HIV transmission from 27 percent to 1.2 percent. This advancement signals the near end to mother-to-child transmission of this deadly disease.

Reducing the Effects of Pelvic Floor Disorders

The Institute has made recent advancements in the area of pelvic floor disorders. The NICHD is investigating whether women that have undergone cesarean sections have fewer incidences of pelvic floor disorder than women who have delivered vaginally.

Reducing the Prevalence of Premature Births

NICHD is helping our Nation understand how adverse conditions and health disparities increase the risks of premature birth in high-risk racial groups.

Drug Safety During Pregnancy

The NICHD recently created the Obstetric and Pediatric Pharmacology Branch to measure drug metabolism during pregnancy.

The Challenge of the Future: Attracting New Researchers

Despite the NICHD's critical advancements, reduced funding has made it difficult for this research to continue, largely due to the lack of new investigators. Congressional programs such as the loan repayment program, the NIH Mentored Research Scientist Development Program for reproductive health, and a small grant program, all attract new researchers, but low pay lines make it difficult for the NICHD to maintain them. Due to the structure of the peer review system, previous grant recipients have an advantage because their grants require fewer funds. This makes it more difficult for new investigators to get into the system, jeopardizing the future of women's health research. We urge the Committee to significantly increase funding at the NICHD to maintain a high level of research innovation and excellence, in turn reducing the incidence of maternal morbidity and mortality and discovering cures for other chronic conditions.

HRSA AND CDC: TURNING RESEARCH INTO PUBLIC HEALTH SOLUTIONS

It is essential that we rapidly transform women's health research findings into public health solutions. HRSA and the CDC have created women and children's health outreach programs based on research conducted on infant mortality, birth defects, gynecological cancers, and a variety of other health issues.

For example, research shows tobacco abuse and health disparities are risk factors for infant mortality. Healthy Start offers programs for States, which fund provider and community education programs that improve maternal health through tobacco cessation programs, and finds ways to decrease the infant mortality rate by investigating cultural and institutional health disparities. Research also shows that early screening and detection of certain strands of the human papilloma virus (HPV) may progress into cervical cancer. By screening thousands of low-income women who would not otherwise receive access to care; this CDC program has saved hundreds of lives.

National Fetal Infant Mortality Review

The Fetal and Infant Mortality Review (FIMR) is a cooperative Federal agreement between ACOG and the Maternal Child Health Bureau at HRSA. FIMR uses the expertise of ob-gyns and local health departments to find solutions to problems related to infant mortality. In light of the increase in the infant mortality rate for 2002, the FIMR program is vital to develop community-specific, culturally appropriate interventions. Today 220+ local programs in 42 States are implementing FIMR and finding it is a powerful tool to bring communities together to address the underlying problems that negatively affect the infant mortality rate.

In order to meet the demand of the increasing number of FIMR programs, NFIMR must be able to continue its activities at an adequate funding level. A rigorous national evaluation of FIMR conducted by Johns Hopkins University has concluded that the FIMR methodology is an effective perinatal initiative. Based on that new research, FIMR can now be called an evidence based MCH intervention. All Healthy Start programs and every locality with disparities in infant outcomes should be actively encouraged to implement this FIMR process. We urge this Committee to recognize the many positive contributions of the FIMR program and ensure it remains a fully funded program within HRSA.

Provider's Partnership

Through May 2003, HRSA funded the Provider's Partnership, a cooperative agreement between the Federal Maternal and Child Health Bureau and ACOG. This Partnership includes a series of State-level projects initiated to address key women's health issues, while simultaneously building partnerships between ACOG Members and public health leadership.

The Partnership works specifically with psychosocial issues that greatly impact the health and well-being of women. The morbidity and mortality attributed to issues such as a woman's depression, tobacco use, substance abuse and domestic violence are becoming increasingly apparent as they weigh on both the woman and her entire family. Without treatment, these psychosocial issues place a heavy financial burden on State and Federal resources. Obstetrician-gynecologists play a critical role in addressing these problems within their current practice; however because of the complexity and the importance of promptly linking at-risk women with appropriate services, responsibility for full psychosocial assessment and treatment cannot fall solely on obstetrician-gynecologists. Partnerships between women's health care physicians and State and community programs are needed that allow for integration of medical care with psychosocial services. Partnerships increase coordination thereby minimizing demands on both the behavioral health care system and individual providers. Provider's Partnership enables stakeholders to improve prevention interventions, so that later complications can be avoided.

There are currently 30 State-level Partnership teams focused on depression in women, tobacco use, perinatal HIV transmission and oral health. These teams have been successful at surveying obstetric providers on their screening; counseling and referral practices for perinatal depression and tobacco use, the results of which have been the basis for the development of statewide legislative and practice policy guidelines; establishing pilot screening and intervention initiatives for depression in women; and instituting provider training and technical assistance for depression and tobacco use screening and intervention. Despite their successes, these teams still struggle for funds to offset administrative and program costs. Representatives from additional States have expressed an interest in developing an ACOG Provider's Partnership; however, any new efforts are being postponed until additional funding can be identified. We urge the committee to restore funding for the Partnership to fiscal year 2003 levels.

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) administered by the CDC is an indispensable health program in helping underserved women gain access to screening programs for early detection of breast and cervical cancers. The NBCCEDP has served over 2.5 million women and provided 5.8 million screening examinations. Early detection and treatment of breast and cervical cancers greatly increase a woman's odds of conquering these diseases. The President's fiscal year 2007 Budget recommends decreasing funding by $1.4 million, preventing access to these services for an estimated 4,000 women per year. We strongly urge the Committee to continue saving women's lives and prevent cuts to this vital program.

National Center on Birth Defects and Developmental Disabilities (NCBDDD)

Birth defects affect about one in every 33 babies born in the United States each year. Babies born with birth defects have a greater chance of illness and long term disability than babies without birth defects. According to the CDC, a great opportunity for further improvement lies in prevention strategies that, if implemented prior to conception, would result in additional improvement of pregnancy outcomes. A cooperative agreement between the NCBDDD and ACOG has resulted in increased provider knowledge of genetic screening and diagnostic tests, technical guidance on routine preconception care and prenatal genetic screening, and improved access to care for women with disabilities.

Again, we would like to thank the Committee for its continued support in addressing the multiple factors that affect maternal and child health. We strongly urge this subcommittee to support increased funding for the NICHD, and renewed appropriations for the maternal child health programs at the CDC and HRSA. By continuing to translate research done at the NICHD into positive outreach programs such as the Provider's Partnership and the NBCCEDP, we can further improve our Nation's overall health.

PREPARED STATEMENT OF THE AMERICAN DIABETES ASSOCIATION

Thank you for the opportunity to submit testimony on the importance of Federal funding for diabetes programs at the Centers for Disease Control and Prevention (CDC) and diabetes research at the National Institutes of Health (NIH).

As the Nation's leading nonprofit health organization providing diabetes research, information and advocacy, the American Diabetes Association feels strongly that Federal funding for diabetes prevention and research efforts is critical not only for the 20.8 million Americans who currently have diabetes, but also for the more than 40 million who have a condition known as "pre-diabetes."

Diabetes is a serious disease, and is a contributing and underlying cause of many of the diseases on which the Federal Government spends the most health care dollars. In addition to the $132 billion in 2002 dollars in direct and indirect costs spent solely on diabetes each year, diabetes is a significant cause of heart disease (which costs our Nation $258.5 billion each year), a significant cause of stroke ($57.9 billion each year), and the leading cause of kidney disease ($40.3 billion). Diabetes is also the leading cause of adult-onset blindness and lower limb amputations.

Approximately 48,000 people suffering from diabetes live in each congressional district and the number of people living with diabetes in this country is growing at a shocking rate. In the last 2 years alone, diabetes prevalence in the United States has increased by 14 percent. The number of Americans with diabetes is now growing at a rate of 8 percent per year and is the single most prevalent chronic illness among children. Because of the systemic havoc that diabetes wreaks throughout the body, it is no surprise that the life expectancy of a person with the disease averages 10–15 years less than that of the general population.

As the statistics listed above illustrate, we are facing an epidemic of diabetes in this country, which if left unchecked could have significant implications for many future generations. A recent study of the diabetes epidemic in New York City warns that diabetes-caused heart attacks threatens to reverse the tremendous gains made in preventing deaths from heart disease. One of the authors of the study termed it "a public health catastrophe." We know, for example, that in every 24 hour period, there will be 4,100 people diagnosed with diabetes, 230 amputations in people with diabetes, 120 people who enter end-stage kidney disease programs and 55 people who go blind. All told, there will be nearly 225,000 deaths from diabetes each year. That is the ultimate cost of underfunding research and prevention programs.

While science continues to work towards finding a cure, we must first adequately fund the diabetes prevention and outreach work being done at the Centers for Disease Control and Prevention. Therefore, we are requesting:

—At least a 10 percent increase over fiscal year 2006 levels for the CDC's Center on Chronic Disease Prevention and Health, including an additional $20.8 million increase for the CDC's Division of Diabetes Translation (DDT), only $1 for each American suffering from diabetes; and

—Restoration of the Preventive Health & Health Services Block Grant.

The CDC's Division of Diabetes Translation is critical to our national efforts to prevent and manage diabetes because they translate the research that has already been done to real programs at the community level. Currently, for every $1 that diabetes costs this country, the Federal Government invests less than $.01 to help Americans prevent and manage this deadly disease. This dynamic must be changed. While the Association strongly believes that significant funding is needed to fully fund programs in all 50 States, our request of $20.8 million will allow these critical programs to expand to an additional 10 States.

In 2005 DDT provided support for more than 50 State- and territorial-based Diabetes Prevention and Control Programs (DPCPs) to increase outreach and education, and reduce the complications associated with diabetes. However, funding constraints required DDT to provide severely limited support to 22 States, 8 territories, and D.C. This level of funding, referred to as "capacity building," allows a State to do surveillance, but is not enough for the State to do much—or anything—in the way of intervention.

DDT was able to provide the higher level of support, "basic implementation," to the other 28 States. At the basic implementation level, States are able to devise and execute community-level programs. With an additional $20.8 million over fiscal year 2006 funding levels, an additional 10 States could start to receive the substantial benefits of basic implementation programs.

The basic implementation programs undoubtedly make a major impact on local communities. For example, the West Virginia DPCP has developed a model education training program in state-of-the-art diabetes care, and has established a work-site health promotion program for State employees. At the same time, by collaborating with the West Virginia Association of Diabetes Educators, the State has

almost doubled the number of certified diabetes educators, and plans to expand that success to underserved rural areas through satellite training programs. Our goal is to make this a reality for the rest of the country, so that communities have the ability to invest in their future by investing in diabetes prevention and education.

Without fully-funded diabetes programs and projects in all parts of the country, it will be exceedingly difficult—if not impossible—to control the escalating costs associated with diabetic complications and to stem the epidemic rise in diabetes rates. State DPCPs, when provided with enough funding, are proven programs that have been extremely successful in helping Americans prevent and manage their diabetes. In the Division of Diabetes Translation Program Review fiscal year 2004, the CDC stated, "The Basic Implementation DPCPs serve as the backbone for our growing primary prevention efforts. These State programs are the key elements to our success in meeting the challenges of controlling and preventing diabetes." For example, the Texas DPCP contracts with local health departments, community health centers, and local non-profits to serve counties throughout the State. These programs have demonstrated success in promoting physical activity, weight and blood pressure control, and smoking cessation for those with diabetes. One of their programs, Coordinated Approach to Child Health (CATCH), is an elementary school program to increase activity levels, improve diets and reduce children's risk for obesity, a leading factor in the development of diabetes in children. Americans in every State should have access to such quality programs. Unfortunately, the Division's fiscal year 2006 budget of just over $63 million, and the President's request for a cut in fiscal year 2007 to $62.42 million, will prevent more counties and States from implementing programs such as the one described above.

In addition to DPCP, the CDC's Division of Diabetes Translation also conducts other activities to help people currently living with diabetes. To put research into action, CDC works with NIH to jointly sponsor the National Diabetes Education Program (NDEP), which seeks to improve the treatment and outcomes of people with diabetes, promote early detection, and prevent the onset of diabetes. The CDC is also currently working to develop a National Public Health Vision Loss Prevention Program that will investigate the economic burden and strengthen the surveillance and research of this all-to-common complication of diabetes. In addition, CDC funds work at the National Diabetes Laboratory to support scientific studies that will improve the lives of people with diabetes. In fiscal year 2005, the Division of Diabetes Translation alone published 53 manuscripts on the care, prevention, and science of diabetes, including 17 abstracts.

The Association appreciates the increased attention by Congress to diabetes research at the National Institutes of Health (NIH) in recent years. While there is not yet a cure for diabetes, researchers at NIH are working on a variety of projects that represent hope for the millions of individuals with Type 1 and Type 2 diabetes. The Association strongly encourages you to provide at least a 5 percent increase to the NIH to fulfill this promise. Unfortunately, while the death rate due to diabetes has increased by more than 40 percent in recent years, diabetes research funding has not kept pace. Indeed, from 1987–2001, appropriated diabetes funding as a share of the overall NIH budget has dropped by more than 20 percent (from 3.9 percent to 2.9 percent). While Congress had initially begun to address this discrepancy, the fiscal year 2006 budget reduced funding at the National Institutes of Diabetes, Digestive and Kidney Diseases (NIDDK) by $9 million. This is unconscionable when diabetes deaths continue to increase at such a rate. The Association believes that NIH research and CDC translational programs go hand in hand in the effort to combat the diabetes epidemic.

The Association is also supportive of restoration of the CDC's Preventive Health & Health Services Block Grant (PBG). The PBG, which allows States to develop innovative health programs at the community level, received $99 million in fiscal year 2006, but is currently slated for no funding for fiscal year 2007. These programs have been very successful. In the State of Louisiana, the grants are used to train school based health personnel on the diagnosis and management of type 2 diabetes, and also to screen adolescents at significant risk for type 2 diabetes. There are 53 school based health centers in Louisiana that are directly assisted by this program. As the State continues to rebuild following Hurricane Katrina, it would be tragic to remove this small but critical piece of health infrastructure funding.

The Association, and the millions of individuals with diabetes we represent, firmly believes that we could rapidly move toward curing, preventing, and managing this disease by increasing funding for diabetes programs and research both at CDC and NIH. Your leadership is essential to accomplishing this goal. As you are considering fiscal year 2007 funding, we ask you to remember that chronic diseases, including diabetes, account for nearly 70 percent of all health care costs as well as 70 percent of all deaths annually. Unfortunately, less than $1.25 per person is directed toward

public health interventions focused on preventing the debilitating effects associated with chronic diseases, demonstrating that Federal investment in chronic disease prevention remains grossly inadequate. We cannot ignore those Americans who are currently living with diabetes and other diseases.

In closing, the American Diabetes Association strongly urges the subcommittee and Congress to provide a 10 percent increase for the CDC's Center on Chronic Disease Prevention and Health, including a $20.8 million increase for the CDC's Division of Diabetes Translation, and to restore the Preventive Health & Health Services Block Grant. Providing this funding would be an important step towards empowering States to fight diabetes at the community level. Additionally, we urge the subcommittee to increase NIH funding by 5 percent to allow for an increased commitment to diabetes research.

On behalf of the 20.8 million Americans with diabetes—a disease that crosses gender, race, ethnicity and political party; a disease that is among the most costly, debilitating, deadly and prevalent in our Nation; and a disease that is exploding throughout our Nation—thank you for the opportunity to submit this testimony. The American Diabetes Association is prepared to answer any questions you might have on these important issues.

PREPARED STATEMENT OF THE AMERICAN FOUNDATION FOR THE BLIND

Mr. Chairman and members of the subcommittee, my name is Paul Schroeder and I am the Vice President for Programs and Policy at the American Foundation for the Blind. Thank you for giving the American Foundation for the Blind (AFB) the opportunity to submit testimony to the subcommittee as you begin to consider funding priorities for fiscal year 2007. The AFB is a national non-profit organization with a commitment to enhancing and promoting the health, education, employment, and overall quality of life for people with vision loss.

For nearly a century AFB has been expanding possibilities for people with vision loss by setting trends and devising innovative programs. For example, AFB works with the corporate sector to get the latest technologies that promote equal access into the hands of people who have vision loss. AFB also promotes the development and dissemination of new ideas and resources for service professionals, and AFB assists consumers with vision loss to maintain independent and healthy lives by providing them and their families with information about services and advice on purchasing decisions. In these and many other ways AFB continues to respond to the current needs of the vision loss community.

The AFB, with headquarters in New York City, and a Public Policy Center in Washington, DC, also operates the National Center on Vision Loss in Dallas, TX, to help ensure that Americans with vision loss have information and access to all technologies needed to maintain their independence. This innovative resource center offers information, education, technology, and training—all under one roof and through the Internet—to create accessible living and work environments for people who are visually impaired. The AFB has launched a $2.4 million campaign—Project Independence—to expand and enhance the Dallas center and ensure it has national reach through web-based and other information dissemination programs. Also this year, the AFB has enhanced its efforts to promote health maintenance and prevention of secondary health conditions among those with vision loss. The testimony that follows will speak in more detail to this issue.

RECOGNIZING THE LEADERSHIP OF THE SUBCOMMITTEE IN SUPPORT OF AMERICANS WITH DISABILITIES

According to the Institute of Medicine's 1991 report Disability in America: Toward a National Agenda for Prevention, "disability is an issue that affects every individual, community, neighborhood and family in the United States." This statement remains equally true today. An estimated 54 million people in the United States currently live with a disability, including severe vision loss. There are approximately 10 million Americans that are blind or have vision impairment, 6.5 million of whom are elderly. With the continued aging of the population, the number of elderly Americans affected by vision loss will only increase.

Mr. Chairman, AFB commends the subcommittee's leadership and commitment to programs of interest and benefit to citizens with disabilities. Within the jurisdiction of the Labor, Health and Human Services, and Education Subcommittee are the vast majority of the Federal programs that support services to people with disabilities. The main focus of our testimony, however, is to highlight for the subcommittee the critically important work of the CDC's National Center on Birth Defects and Developmental Disabilities.

THE CDC'S NATIONAL CENTER ON BIRTH DEFECTS AND DEVELOPMENTAL DISABILITIES

Mr. Chairman, on behalf of the American Foundation for the Blind, I would like to commend the leadership of the CDC's National Center on Birth Defects and Developmental Disabilities (NCBDDD) for their hard work and dedication to their mission to promote the health and wellness of children and adults living with disabilities. We are particularly pleased and supportive of the Center's new focused initiatives to address the secondary health effects of people with vision loss and other disabilities.

It has been widely documented that individuals with disabilities experience negative health, social, emotional, family, and community outcomes at higher rates than others. Sadly, 20.1 percent of people with disabilities lack health insurance, as compared to 17.8 percent of the general population. Moreover, secondary conditions such as heart disease, diabetes and stroke, all of which are modifiable and preventable, are also particularly acute among Americans with vision loss. For example, elderly Americans with vision loss have higher rates of depression, hypertension, heart disease, stroke, and physical injuries than people without these sensory impairments. Unique to individuals with vision loss is the risk of prescription errors stemming from inaccessible print labeling and/or instructions about safe administration of the drugs.

These disparities in health have multiple consequences including the decreased ability to perform valued activities, participate in social roles including employment, and ever-escalating costs associated with deteriorating health conditions.

Many Americans with vision impairment, however, could substantially improve their every day lives and prevent the onset of secondary conditions with appropriate health interventions and information. To ensure that this help is available, additional research to strengthen the evidence base for effective public health interventions needs to be conducted. In addition, substantially enhanced dissemination programs of these interventions through a website and other means accessible to people with vision loss is a vital component of such a program. Such a dedicated program would be of significant benefit to those facing vision loss and their families. The initiation of such a program at the National Center on Birth Defects and Developmental Disabilities would reduce health disparities and push forward the public health frontier in assisting people with blindness and vision loss.

RECOMMENDATIONS

Mr. Chairman, the administration's request for the National Center on Birth Defects and Developmental Disabilities is $110,481,000, a decrease of $14.28 million below fiscal year 2006 levels. If enacted, this would be the second year in a row that the incredibly important programs funded in this national Center received cuts. AFB strongly encourages the subcommittee to reverse these reductions and to specifically add $950,000 for a dedicated program to ameliorate and prevent secondary health conditions that affect individuals with vision loss. AFB would also encourage the subcommittee to support an expansion of the proposed Center on Vision Loss in Dallas, Texas.

SUMMARY AND CONCLUSIONS

Mr. Chairman, again we wish to thank the subcommittee for its past leadership and commitment to disability issues. With your leadership much additional progress can be made to improve the lives and health of Americans with vision loss.

Thank you for this opportunity to testify.

PREPARED STATEMENT OF THE AMERICAN PHYSIOLOGICAL SOCIETY

The American Physiological Society (APS) thanks the subcommittee for its sustained support for the National Institutes of Health (NIH). The doubling of the agency budget that took place between fiscal years 1996 and 2002 allowed the NIH to expand its efforts to address old and new challenges in biomedical science. Our Nation's investment in basic, translational, and clinical research plays an important role in the continued health and prosperity of our people. Increases in NIH funding have allowed researchers to explore scientific opportunities on an unprecedented scale. However, to build on existing knowledge and explore new areas, NIH must be able to provide research support for innovative ideas. In fiscal year 2006 the NIH budget was cut for the first time since 1970, and the administration's fiscal year 2007 budget proposal would keep the agency at the same level. Taking inflation into account, the President's budget plan represents another budget cut that will reduce the number of research grants funded. As funding falters, the best and brightest

minds will turn away from careers in medical science. If NIH cannot fund new ideas, this will not only hamper efforts to find cures, it will also discourage up and coming researchers who could become the next generation of basic and clinical scientists. The APS urges you to make every effort to provide the NIH with a 5 percent funding increase so we can take advantage of more scientific opportunities that will lead to ways to alleviate the suffering and burdens of disease and strengthen the Nation's scientific workforce to face future challenges.

The APS is a professional society dedicated to fostering research and education as well as the dissemination of scientific knowledge concerning how the organs and systems of the body work. The Society was founded in 1887 and now has more than 10,000 member physiologists across the United States. The APS offers these comments on the budget recognizing both the enormous financial challenges facing our Nation and the enormous opportunities before us to make progress against disease.

NIH's task is both to cure specific diseases and to look broadly at scientific opportunities that may help us expand our understanding of biological problems that affect health. Basic research contributes to a body of knowledge whose importance will only be determined over time. Physiology, which is the study of biological function, provides the foundation for much of the translational research that turns discoveries into therapies and prevention strategies.

One example of this is the lung disease cystic fibrosis. Over the last 20 years, the scientific community has made great leaps in understanding the role that genes play in the development of various diseases. The CFTR gene responsible for cystic fibrosis was identified in 1989. Since then, researchers have worked to gain a better understanding of what happens in the disease at the molecular level with the hope of developing a gene therapy that would prolong and improve patients' lives. One critical question was how much of the normal gene is necessary to improve lung function. In late 2005, NIH supported researchers at the University of Iowa published the results of experiments in which they delivered healthy copies of the CFTR gene to cultured lung cells taken from cystic fibrosis patients.[1] They were then able to measure whether function improved with increasing amounts of gene product. Unexpectedly, delivery of low levels of the CFTR gene was more effective than very high doses. This type of experiment provides the foundation for designing safe and effective clinical treatments.

In addition to supporting research, the NIH must also address workforce issues to be sure our Nation's researchers are ready to meet the challenges they will face in the future. Last year the NIH announced a new program to encourage clinical and translational research at universities. The new Clinical and Translational Service Awards (CTSAs) will provide a total of $30 million in fiscal year 2006 to develop new research and training programs at academic institutions around the country. This will allow researchers to capitalize on knowledge generated from basic research through the development of clinical applications and treatments.

The NIH plays many critical roles in advancing biomedical research. It provides opportunities for individual researchers at universities and medical schools throughout the country to compete for research funds based upon the scientific merit of their ideas. NIH also carries out other functions including:

—Sponsoring research training opportunities for young scientists and physicians;
—Funding major collaborative initiatives that bring together multiple institutions with diverse resources;
—Providing the public with up-to-date information about the latest research on various diseases and health conditions through individual institutes and online resources such as "MedLine Plus" and ClinicalTrials.gov;
—Supporting unique science education programs, particularly for underserved minority students; and
—Funding innovative research through the NIH Roadmap initiative.

These activities are critical to moving science forward, and they are unique to the NIH. Another example is the newly developed Genes and Environment Initiative (GEI). The GEI is a multi-institute effort to identify genetic and environmental risk factors that contribute to common diseases such as asthma, diabetes, heart disease, cancer and Alzheimer's disease. The planned research will build on the Human Genome Project and take advantage of new technologies developed in the pursuit of basic research. With its wide range of expertise, the NIH is uniquely suited to undertake broad projects such as this.

The examples listed above represent a select few examples from the NIH's extensive and outstanding portfolio. The APS joins the Federation of American Societies for Experimental Biology (FASEB) and the Ad Hoc Group for Medical Research Funding in urging that NIH be provided with a 5 percent funding increase in fiscal

[1] S. L. Farmen et al., Am J Physiol Lung Cell Mol Physiol 289, L1123–30 (Dec. 2005).

year 2007 to permit the agency to maintain its current wide-ranging and important research efforts. This forward-looking approach to our Nation's biomedical research efforts is much to be preferred over the administration's proposal to fund the agency at last year's level, which would force the NIH to contract its research portfolio, thus leaving many important projects unfunded.

PREPARED STATEMENT OF THE COALITION OF NORTHEASTERN GOVERNORS

The Coalition of Northeastern Governors (CONEG) is pleased to provide this testimony for the record to the Senate Subcommittee on Labor, Health and Human Services, Education, and Related Agencies regarding fiscal year 2007 appropriations for the Low Income Home Energy Assistance Program (LIHEAP). The Governors appreciate the subcommittee's consistent support for the LIHEAP program. We also welcome the additional fiscal year 2006 funds recently provided by the Congress, even as we recognize the difficult challenges facing the subcommittee in this time of severe fiscal constraints. However, in light of sharply higher home energy prices, we request the subcommittee to provide the full authorized amount of $5.1 billion in regular fiscal year 2007 LIHEAP funding—to restore the purchasing power of the LIHEAP program. In addition, we request that the subcommittee provide contingency funds to address energy emergency situations.

The continuing trend in rising prices for natural gas and home heating fuels is creating a growing home energy crisis for low-income citizens across the Nation. Low-income households, whose percentage of income spent on energy may be four times that of average households, can amass significant home energy debt that makes it difficult to purchase heating fuels or pay outstanding utility bills. High levels of accumulated arrearages owed by low-income households raise the prospect of hundreds of thousands of households cut off from utility service this spring.

Particularly in the Northeast, which is heavily dependent on deliverable home heating fuels such as home heating oil, kerosene, and propane, price volatility has an especially perverse impact. These low-income households, without the disposable income to purchase fuels off-season, typically enter the market when both the demand for and price of fuels are high. Without access to LIHEAP assistance during the heating season, they may not be able to obtain any fuel at all, due to the collect-on-delivery business policy commonly used by fuel dealers. If LIHEAP benefit levels are too low, these households may not be able to afford the cost of the required minimum delivery.

LIHEAP is a vital tool in making home energy more affordable for almost 5 million of the Nation's very low-income households faced with high energy burden—the elderly and disabled on fixed incomes and families with young children. Over the past 5 years, as the average price of home heating oil and natural gas more than doubled, the purchasing power of the LIHEAP grant has plummeted—undercutting the ability of the program to serve adequately these vulnerable households. States across the country in recent years have seen significant increases in their regular LIHEAP caseloads, as well as in requests for emergency crisis from those households in imminent danger of a utility or fuel service cut-off. The number of requests for LIHEAP assistance has reached its highest level in more than a decade. In response to the continually rising home energy costs and the growing crisis in this recent heating season, States across the country have stepped in to provide more than $450 million for low-income energy programs. In addition to regulatory actions, such as extending shut-off moratoria periods and limiting deposit and reconnection fees, many State public utility commissions have provided more than $100 million in assistance from funding sources such as public benefit funds or universal service funds.

The LIHEAP program delivers maximum program dollars to households in need—the consequence of its administrative costs being among the lowest of human service programs. In the Northeast, States have incorporated various administrative strategies designed to minimize the amount of program funds used to operate the program. Innovative administrative strategies include the use of uniform application forms to determine program eligibility, establishment of a one-stop shopping approach for the delivery of LIHEAP and related programs, sharing administrative costs with other programs, and the use of mail recertification.

The recent action by Congress to increase LIHEAP funding in fiscal year 2006 is a welcome and important step to begin restoring some of the lost LIHEAP purchasing power. However, the prospect of continued high and potentially volatile prices for home energy means that the projected need continues to outweigh available Federal and State funding. Even with these additional Federal and State funds, the value of the LIHEAP grant has been significantly reduced, defraying only

a modest amount of a low-income household's total heating bill; and it reaches only a small percentage of the households that need assistance.

Increased Federal funding is vital for LIHEAP to assist the Nation's vulnerable, low-income households faced with unaffordable home energy bills. An increase in the regular LIHEAP appropriation to the full authorized level of $5.1 billion for fiscal year 2007 in addition to contingency funds, will enable our States to help mitigate the potential life-threatening emergencies and economic hardship that confront the Nation's most vulnerable citizens. With these additional funds, States can provide assistance to more households in need, offer benefit levels that can make a meaningful reduction in their home energy burden, lessen the need for emergency crisis, plan and operate a more efficient program, and again make optimal use of leveraging and other cost-effective programs.

We thank the subcommittee for this opportunity to share the views of the Coalition of Northeastern Governors, and we stand ready to provide you with any additional information on the importance of the Low Income Home Energy Assistance Program to the Northeast.

PREPARED STATEMENT OF THE AMERICAN LUNG ASSOCIATION

SUMMARY: FUNDING RECOMMENDATIONS

[In millions of dollars]

Agency	Amount
National Institutes of Health	30,205
National Heart, Lung, and Blood Institute	3,099
National Cancer Institute	5,030
National Institute of Allergy and Infectious Disease	4,682
National Institute of Environmental Health Sciences	680
National Institute of Nursing Research	146
Fogarty International Center	70
Centers for Disease Control and Prevention	8,500
National Institute for Occupational Safety and Health	285
Office on Smoking and Health	145
Environmental Health: Asthma Activities	70
Tuberculosis Control Programs	252
Influenza Pandemic	2,652

The American Lung Association is pleased to present our recommendations for programs in the Labor Health and Human Services and Education Appropriations Subcommittee purview. These appropriations will make a difference in the lives of millions of Americans who suffer from lung disease.

The American Lung Association is one of the oldest voluntary health organizations in the United States, with a National Office and constituent associations around the country. Founded in 1904 to fight tuberculosis, the American Lung Association today fights lung disease in all its forms, with special emphasis on funding research for cures, promoting cleaner air and helping prevent kids from smoking. The Lung Association is funded by contributions from the public, along with gifts and grants from corporations, foundations and government agencies, and achieves its many successes through the work of thousands of committed volunteers and staff.

THE TOLL OF LUNG DISEASE

Each year, an estimated 349,000 Americans die of lung disease. Lung disease is America's number three killer, responsible for one in every seven deaths. More than 35 million Americans suffer from a chronic lung disease. Each year lung disease costs the economy an estimated $157.8 billion. Lung diseases represent a spectrum of chronic and acute conditions that interfere with the lung's ability to extract oxygen from the atmosphere, protect against environmental or biological challenges and regulate a number of metabolic processes. Lung diseases include: asthma, chronic obstructive pulmonary disease, lung cancer, tuberculosis, pneumonia, influenza, sleep disordered breathing, pediatric lung disorders, occupational lung disease and sarcoidosis.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Chronic Obstructive Pulmonary Disease, or COPD, is a growing health problem. Yet it remains relatively unknown to most Americans and much of the research community. COPD refers to a group of largely preventable diseases, including emphysema and chronic bronchitis, that generally gradually limit the flow of air in the body. COPD is the fourth leading cause of death in the United States and worldwide.

In 2004, the annual cost to the Nation for COPD was $37.2 billion. This includes $20.9 billion in direct health care expenditures, $8.9 billion in indirect morbidity costs and $7.4 billion in indirect mortality costs. Medicare expenses for COPD beneficiaries were nearly 2.5 times that of the expenditures for all other patients.

It has been estimated that 11.4 million patients have been diagnosed with some form of COPD and as many as 24 million adults may suffer from its consequences. In 2004, an estimated 9 million Americans were diagnosed with chronic bronchitis by a health professional. Further, an estimated 3.6 million Americans have been diagnosed with emphysema in their lifetime. In 2002, 120,555 people in the United States died of COPD. Women have exceeded men in the number of deaths attributable to COPD since 2000. Over the past 30 years, the death rate due to COPD has doubled while the death rates for heart disease, cancer and stroke have decreased by over 50 percent.

Today, COPD is treatable but not curable. Fortunately, promising research is on the horizon for COPD patients. Research on the genetic susceptibility underlying COPD is making progress. Research is also showing promise for reversing the damage to lung tissue caused by COPD.

Despite these promising research leads, the American Lung Association believes that research resources committed to COPD are not commensurate with the impact COPD has on the United States and the world.

The American Lung Association strongly recommends that the NIH and other Federal research programs commit additional resources to COPD research programs. In addition, there is a need for improved surveillance data on the disease. The Lung Association supports the CDC in gathering more information about COPD as part of the National Health and Nutrition Examination Survey, the Behavioral Risk Factor Surveillance System and other health surveys. This information will help public health professionals and researchers understand the disease better and lead to possible control of the disease.

TOBACCO USE

Tobacco use is the leading preventable cause of death in the United States, killing more than 438,000 people every year. Smoking is responsible for one in five U.S. deaths. The direct health care and lost productivity costs of tobacco-caused disease and disability are also staggering, an estimated $167 billion each year. Taxpayers pay billions of dollars each year to treat tobacco-caused disease through federally funded health programs including Medicare and Medicaid.

The CDC's Office on Smoking and Health provides significant technical assistance to States that are using tobacco settlement dollars to develop comprehensive and effective tobacco prevention programs, in addition to providing a small, yet essential, amount of Federal assistance directly to State tobacco control and prevention programs. States that currently fund comprehensive programs, as well as those seeking to develop programs, rely on CDC's expertise. Funds for tobacco prevention at CDC also are used to maintain comprehensive information on smoking and health and to support ongoing research on tobacco-related issues.

We believe Congress should fund the type of youth tobacco prevention programs that science tells us are essential to counter the impact of tobacco company marketing to our kids. The American Lung Association strongly supports a minimum level of $145 million in fiscal year 2007 funding for the CDC's Office on Smoking and Health.

ASTHMA

Asthma is a chronic lung disease in which the bronchial tubes become swollen and narrowed, preventing air from getting into or out of the lung. An estimated 30.2 million Americans have ever been diagnosed with asthma by a health professional. Approximately 20.5 million Americans currently have asthma, of which 11.7 million had an asthma attack in 2004. Asthma prevalence rates are 39 percent higher among African Americans than whites. Studies also suggest that Puerto Ricans have higher asthma prevalence rates and age-adjusted death rates than all other Hispanic subgroups.

Asthma is expensive. The growth in the prevalence of asthma will have a significant impact on our Nation's health expenditures, especially Medicaid. Asthma incurs an estimated annual economic cost of $16.1 billion to our Nation. Asthma is the third leading cause of hospitalization among children under the age of 15. It is also the number one cause of school absences attributed to chronic conditions. The Federal response to asthma has three components: research, programs and planning. We are making progress on all three fronts but more must be done:

Asthma Research

Researchers are developing better ways to treat and manage chronic asthma. Two examples show why this should continue. Research supported by National Heart, Lung and Blood Institute (NHLBI) has shown that using corticosteroids to treat children with mild to moderate asthma is safe and effective, answering a parent's question about whether these effective drugs would stunt the growth of children who used them.

Genetic research is also providing insights into asthma. Researchers in the NHLBI-supported Asthma Clinical Research Network have discovered that a genetic variation determines how well asthma patients will respond to the most common asthma medication, inhaled beta-agonists. This discovery will help physicians better target the drugs they proscribe.

Asthma Programs

Last year, Congress provided approximately $31.9 million for the Centers for Disease Control and Prevention (CDC) to conduct asthma programs. The American Lung Association recommends that CDC be provided $70 million in fiscal year 2007 to expand its asthma programs. This funding includes State asthma planning grants, which leverage small amounts of funding into more comprehensive State programs.

Asthma Surveillance

In addition to public education programs, the CDC has been piloting programs to determine how to establish a nationwide health-tracking system. The pilots have shown how to integrate different data to determine how pervasive asthma is in these communities. Congress needs to increase funding to create a nationwide health-tracking system, based on the localized pilots that are underway now.

LUNG CANCER

An estimated 350,679 Americans are living with lung cancer. During 2005, an estimated 172,570 new cases of lung cancer will be diagnosed. This year 163,510 Americans will die from lung cancer. Survival rates for lung cancer tend to be much lower than those of most other cancers. Men have higher rates of lung cancer than women. However, over the past 30 years, the lung cancer age-adjusted incidence rate has decreased 9 percent in males compared to an increase of 143 percent in females. Further, African Americans are more likely to develop and die from lung cancer than persons of any other racial group.

Given the magnitude of lung cancer and the enormity of the death toll, the American Lung Association strongly recommends that the NIH and other Federal research programs commit additional resources to lung cancer research programs. We support increasing the National Cancer Institute budget to $5.003 billion.

INFLUENZA

Influenza is a highly contagious viral infection and one of the most severe illnesses of the winter season. It is responsible for an average of 200,000 hospitalizations and 36,000 deaths each year. Further, the emerging threat of a pandemic influenza is looming. Public health experts warn that over half a million Americans could die and over 2.3 million could be hospitalized if a moderately severe strain of a pandemic flu virus hits the United States. To prepare for a potential pandemic, the American Lung Association supports funding the Federal Pandemic Influenza Plan at the recommended level of $2.652 billion.

TUBERCULOSIS

Tuberculosis is an airborne infection caused by a bacterium, *Mycobacterium tuberculosis* (TB). TB primarily affects the lungs but can also affect other parts of the body, such as the brain, kidneys or spine. There are an estimated 10 million to 15 million Americans who carry latent TB infection. Each has the potential to develop active TB in the future. About 10 percent of these individuals will develop active

TB disease at some point in their lives. In 2005, there were 14,093 cases of active TB reported in the United States.

The American Lung Association has endorsed the Institute of Medicine (IOM) report, *Ending Neglect: The Elimination of Tuberculosis in the United States*, IOM report and its recommendations on how to eliminate TB in the United States. While declining overall TB rates are good news, the emergence and spread of multi-drug resistant TB pose a significant threat to the public health of our Nation. Continued support is needed if the United States is going to continue progress toward the elimination of TB. We estimate it will cost $528 million for the CDC Tuberculosis Elimination Program to implement the report recommendations. We request that Congress increase funding for tuberculosis programs to $252 million for fiscal year 2007.

The NIH also has a prominent role to play in the elimination of TB. Currently there is no highly effective vaccine to prevent TB transmission. However, the recent sequencing of the TB genome and other research advances has put the goal of an effective TB vaccine within reach. In addition, the American Lung Association encourages the subcommittee to fully fund the TB vaccine blueprint development effort at the National Institutes of Allergy and Infectious Disease (NIAID).

Fogarty International Center TB Training Programs

The Fogarty International Center (FIC) at NIH provides training grants to U.S. universities to teach AIDS treatment and research techniques to international physicians and researchers. Because of the link between AIDS and TB infection, FIC has created supplemental TB training grants for these institutions to train international health care professionals in the area of TB treatment and research. However, we believe TB training grants should not be offered exclusively to institutions that have received AIDS training grants. The TB grants program should be expanded and open to competition from all institutions. The American Lung Association recommends Congress provide $70 million for FIC to expand the TB training grant program from a supplemental grant to an open competition grant.

ENVIRONMENTAL HEALTH

The National Institute of Environmental Health Sciences funds vital research on the impact of environmental influence on disease. The American Lung Association supports increasing the appropriation from this subcommittee to $680 million.

RESEARCHING AND PREVENTING OCCUPATIONAL LUNG DISEASE

The American Lung Association recommends that the subcommittee provide $285 million for the National Institute for Occupational Safety and Health (NIOSH) at the CDC.

CONCLUSION

In conclusion, Mr. Chairman, lung disease is a continuing, growing problem in the United States. It is America's number three killer, responsible for one in seven deaths. The lung disease death rate continues to climb. Mr. Chairman, the level of support this committee approves for lung disease programs should reflect the urgency illustrated by these numbers.

PREPARED STATEMENT OF THE AMERICAN NEPHROLOGY NURSES' ASSOCIATION

The American Nephrology Nurses' Association (ANNA) appreciates the opportunity to submit written comments for the record regarding fiscal year 2007 funding to address the challenges that kidney disease and the nursing shortage are posing to the Nation. ANNA exists to advance nephrology nursing practice and positively influence outcomes for patients with kidney or other disease processes requiring replacement therapies through advocacy, scholarship, and excellence. ANNA consists of more than 12,000 registered nurses and other health care professionals with varying experience and expertise in such areas as hemodialysis, peritoneal dialysis, conservative management, continuous renal replacement therapies, chronic kidney disease, and renal transplantation.

As part of our mission, we educate health professionals, the public, and policymakers to increase public awareness and understanding of the unique health care needs and challenges people with kidney disease face. Moreover, ANNA maintains a strong commitment to securing public policies and programs that help secure better treatments and care for individuals with kidney disease. ANNA specifically seeks to advance public and private efforts to improve treatment of kidney disease,

reduce and prevent the onset of end stage renal disease (ESRD), and ensure that all people with kidney disease have access to the medical care and treatment options they need to live the highest quality of life possible.

To that end, ANNA respectfully requests that Congress reject the President's proposed $11 million cut in funding for the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and instead support increased funding for diabetes and kidney disease research to find better treatments, preventive interventions, and develop a cure. NIDDK conducts and supports research on most of the more serious diseases affecting public health. The Institute supports much of the clinical research on the diseases of internal medicine and related subspecialty fields, as well as many basic science disciplines. Additional fiscal year 2007 funding for NIDDK will help advance our Nation's understanding of the risk factors associated with kidney disease, boost efforts to identify ways in which kidney disease can be reduced and prevented, and increase initiatives to improve care and treatment of individuals with chronic kidney disease as well as those with ESRD.

The National Institute of Nursing Research (NINR) supports clinical and basic research to establish a scientific basis for the care of individuals across the life span-from management of patients during illness and recovery to the reduction of risks for disease and disability, the promotion of healthy lifestyles, promoting quality of life in those with chronic illness, and care for individuals at the end of life. NINR seeks to understand and ease the symptoms of acute and chronic illness, to prevent or delay the onset of disease or disability or slow its progression, to find effective approaches to achieving and sustaining good health, and to improve the clinical settings in which care is provided. Importantly, NINR research also focuses on the special needs of at-risk and under-served populations, with an emphasis on health disparities, such as those seen among the ESRD population. These efforts are crucial in the creation of scientific advances and their translation into cost-effective health care that does not compromise quality. ANNA is pleased to join with others in the nursing community in advocating a fiscal year 2007 allocation of $150 million for NINR.

As you know, the Nation is facing a nursing shortage of unprecedented proportion. At the same time the nursing shortage is expected to worsen, the number of people with ESRD needing access to state-of-the-art treatment and care is estimated to increase significantly. More than 350,000 Americans have ESRD which gives the United States the highest incidence rate. As the population continues to grow and age and medical services advance, the need for nurses will continue to increase. A report issued by the U.S. Health Resources and Services Administration (HRSA), Projected Supply, Demand, and Shortages of Registered Nurses: 2000–2020, predicted that the nursing shortage is expected to grow to 29 percent by 2020, compared to a seven percent shortage in 2005. Nurses are crucial to the health of our Nation and those with ESRD.

According to the U.S. Department of Health and Human Services (HHS), the nursing workforce programs housed at HRSA will support the recruitment, education, and retention of an estimated 36,750 nurses and nursing students and approximately 956 new loan repayments and scholarships among other activities. With additional funding in fiscal year 2007, the HRSA nursing workforce programs would have more sufficient resources to bolster the Nation's nursing workforce at a rate necessary to help stem the nursing shortage tide. To address this current and growing challenge in the health care delivery system, ANNA urges Congress to support the nursing community's request of $175 million for the HRSA nursing workforce programs. Moreover, please note that ANNA supports the written testimony submitted by the Americans for Nursing Shortage Relief (ANSR) Alliance and respectfully requests your full and fair consideration of the funding allocations and issues outlined by ANSR.

Please know that we understand that Congress has limited resources to allocate. However, we are concerned that without adequate funding for research and the Nation's nursing workforce, the Nation will falter in its efforts to diminish suffering from kidney disease and to provide quality nursing care to all in need. On behalf of ANNA's Board of Directors and the hundreds of thousands of individuals with kidney disease to whom we provide care, thank you for this opportunity to submit written testimony regarding the fiscal year 2007 funding levels necessary to ensure that our Nation adequately supports kidney disease research and the Nation's nursing workforce. Please feel free to contact us at any time; we are happy to be a resource to subcommittee members and your staff.

PREPARED STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association (APHA) is the Nation's oldest, largest and most diverse organization of public health professionals in the world, dedicated to protecting all Americans and their communities from preventable, serious health threats and assuring community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States. We are pleased to submit our views on Federal funding for public health activities in fiscal year 2007.

RECOMMENDATIONS FOR FUNDING THE PUBLIC HEALTH SERVICE

The APHA's budget recommendation for overall funding for the Public Health Service includes funding for the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Agency for Healthcare Research and Quality (AHRQ), and the National Institutes of Health (NIH), as well as agencies outside the subcommittee's jurisdiction—the Food and Drug Administration (FDA) and the Indian Health Service (IHS). We encourage the subcommittee to restore $1 billion in funding cuts that occurred in fiscal year 2006, and reject the President's proposal to cut an additional $600 million from the Public Health Service.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

The APHA believes that Congress should support CDC as an agency—not just the individual programs that it funds. We support a funding level for CDC that enables it to carry out its mission to protect and promote good health and to assure that research findings are translated into effective State and local programs.

In the best professional judgment of the APHA, in conjunction with the CDC Coalition—given the challenges of terrorism and disaster preparedness, new and reemerging infectious diseases, the epidemic of obesity, particularly among children, and our many unmet public health needs and missed prevention opportunities—we believe the agency will require funding of at least $8.5 billion, plus sufficient funding to prepare the Nation against a potential influenza pandemic. This request reflects the support CDC will need to fulfill its core missions for fiscal year 2007, as well as funding for the Agency for Toxic Substances and Disease Registry and the Vaccines for Children program.

The APHA appreciates the subcommittee's work over the years, including your recognition of the need to fund chronic disease prevention, infectious disease prevention and treatment, and environmental health programs at CDC. By translating research findings into effective intervention efforts, CDC has been a key source of funding for many of our State and local programs that aim to improve the health of communities. Perhaps more importantly, Federal funding through CDC provides the foundation for our State and local public health departments, supporting a trained workforce, laboratory capacity and public health education communications systems.

CDC also serves as the command center for our Nation's public health defense system against emerging and reemerging infectious diseases. With the potential onset of an influenza pandemic, in addition to the many other natural and manmade threats that exist in the modern world, the CDC has become the Nation's—and the world's—expert resource and response center, coordinating communications and action and serving as the laboratory reference center. States and communities rely on CDC for accurate information and direction in a crisis or outbreak.

Unfortunately, Congress cut overall CDC funding in fiscal year 2006 for the first time in 25 years. And in fiscal year 2007, the President has proposed cutting CDC funding even more—more than 2 percent overall, and more than 4.5 percent to CDC's core programs. We are moving in the wrong direction, especially in these challenging times when public health is being asked to do more, not less. In light of the current workload placed on the public health service—in addition to the threat of emerging diseases such as the avian flu—it simply does not make any sense to cut the budget for CDC at a time when the threats to public health are so great. Funding public health outbreak by outbreak is not an effective way to ensure either preparedness or accountability. Until we are committed to a strong public health system, every crisis will force trade offs.

CDC serves as the lead agency for bioterrorism preparedness and must receive sustained support for its preparedness programs in order for our Nation to meet future challenges. APHA supports the proposed increase for anti-terrorism activities at CDC, including the increases for the Strategic National Stockpile and the new

Botulinum Toxin Research funding. However, we strongly caution that the President's proposed level-funding of the State and local capacity grants continues to reflect a $95 million cut from fiscal year 2005 levels. We encourage the subcommittee to restore these cuts to ensure that our States and local communities can be prepared in the event of an act of terrorism.

Unfortunately, the President's budget proposes the elimination of some very important CDC programs, like the Preventive Health and Health Services Block Grant. Within an otherwise-categorical funding construct, the Preventive Health and Health Services Block Grant is the only source of flexible dollars for States and localities to address their unique public health needs. The track record of positive public health outcomes from Prevention Block Grant programs is strong, yet so many requests go unfunded. However, the President's budget proposes the elimination of the Preventive Health and Health Services Block Grant—again. We appreciate the work of the subcommittee to at least partially restore the fiscal year 2006 elimination of the Block Grant. Nevertheless, the $20 million cut to the Block Grant in fiscal year 2006 reduces the States' ability to tailor Federal public health dollars to their specific needs. As States use their Prevention Block Grant dollars to address high priority needs such as emerging and chronic diseases, child safety seat programs, suicide prevention, smoke detector distribution and fire safety programs, adult immunization, oral health, worksite wellness, infectious disease outbreaks, food safety, emergency medical services, safe drinking water, and surveillance needs—we can scarcely understand why the Prevention Block Grant should be eliminated. We encourage the subcommittee to restore the cuts and fund the Prevention Block Grant at $132 million.

We also encourage the subcommittee to provide $10 million for CDC's Environmental Public Health Services Branch to revitalize environmental public health services at the national, State, and local level. As with the public health workforce, the environmental health workforce is declining. Furthermore, the agencies that carry out these services are fragmented and their resources are stretched. These services are the backbone of public health and are essential to protecting and ensuring the health and well being of the American public from threats associated with West Nile virus, terrorism, E. coli and lead in drinking water.

We appreciate the subcommittee's hard work in advocating for CDC programs in a climate of competing priorities.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

HRSA programs are designed to give all Americans access to the best available health care services. Through its programs in thousands of communities across the country, HRSA provides a health safety net for medically underserved individuals and families, including more than 45 million Americans who lack health insurance; 50 million Americans who live in neighborhoods where primary health care services are scarce; African American infants, whose infant mortality rate is more than double that of whites; and the estimated 1 to 1.2 million people living with HIV/AIDS. Programs to support the underserved place HRSA on the front lines in erasing our Nation's racial/ethnic and rural/urban disparities in health status. HRSA funding goes where the need exists, in communities all over America. We support a growing trend in HRSA programs to increase flexibility of service delivery at the local level, necessary to tailor programs to the unique needs of America's many varied communities. The agency's overriding goal is to achieve 100 percent access to health care, with zero disparities. In the best professional judgment of the APHA, to respond to this challenge, the agency will require an overall funding level of at least $7.5 billion for fiscal year 2007.

The APHA is gravely concerned about a number of programs that are slated for deep cuts or elimination under the administration's budget proposal. Building on the HRSA programs that were cut or eliminated in the fiscal year 2006 appropriations bill, we strongly suggest that this trend is moving our Nation in the wrong direction. We urge the subcommittee to restore funding to HRSA programs that were cut last year, as well as ensure adequate funding for fiscal year 2007 by rejecting the proposed cuts contained in the President's budget.

We express our dismay at the eroding support from the subcommittee for some of HRSA's programs over the last few years, including Health Professions programs, Area Health Education Centers, and the Maternal and Child Health block grant, among others. On top of the $250 million cut to the agency for fiscal year 2006, the President has proposed another $321 million overall cut from last year's appropriated level. Under the President's proposal, total cuts to HRSA since fiscal year 2005 would reach more than $570 million, a devastating 8 percent cut in 2 years.

We urge the subcommittee to restore the fiscal year 2006 cuts, and reject the President's proposed cuts for fiscal year 2007.

One program that has received consistent support from the subcommittee is the community-based health centers and National Health Service Corps-supported clinics, which form the backbone of the Nation's health safety net. More than 4,000 of these sites across the Nation provide needed primary and preventive care to 15 million poor and near-poor Americans. HRSA primary care centers include community health centers, migrant health centers, health care for the homeless programs, public housing primary care programs and school-based health centers. Health centers provide access to high-quality, family-oriented, culturally and linguistically competent primary care and preventive services, including mental and behavioral health, dental and support services. Nearly three-fourths of health center patients are uninsured or on Medicaid, two-thirds are people of color, and more than 90 percent live below 200 percent of the poverty level. Additional primary care is provided by 2,700 clinicians in the National Health Service Corps. Corps members work in communities with a shortage of health professionals in exchange for scholarships and loan repayments. The APHA is pleased that the President has requested a significant increase for Community Health Centers for a total of $1.918 billion.

Nevertheless, in the context of corresponding cuts to the Health Professions programs, we are left with some doubt about who, exactly, is going to staff all these new Community Health Centers. We are once again very concerned that the HRSA health professions programs under Title VII and VIII of the Public Health Service Act have landed on the chopping block. Today our Nation faces a widening gap between challenges to improve the health of Americans and the capacity of the public health workforce to meet those challenges. An adequate, diverse, well-distributed and culturally competent health workforce is indispensable to our national readiness efforts and to address critical health care needs. These programs help meet the health care delivery needs of the areas in this country with severe health professions shortages, at times serving as the only source of health care in many rural and disadvantaged communities. Therefore, the elimination of most funding for the Title VII health professions training programs and flat funding for Title VIII nurse training will only make certain that the needs of these medically underserved populations will not be met.

Furthermore, we believe the elimination of the Healthy Community Access Program, universal newborn hearing screening programs, and the Emergency Medical Services for Children Program, will further undermine the availability of basic health services for some that are most in need—especially children. The Healthy Community Access Program is an example in which communities build partnerships among health care providers to deliver a broader range of health services to their neediest residents. This program of coordinated service delivery is innovative, not duplicative of other available programs, and therefore its elimination is of grave concern. Also, the proposed zero funding of universal newborn hearing screening programs in the administration's budget will likely cause many hearing impairments in infants to go undetected, which can negatively impact speech and language acquisition, academic achievement, and social and emotional development. The proposed elimination of the Emergency Medical Services for Children Program will likely halt the improvements made in recent years to pediatric emergency care, which will disproportionately affect children who are eligible for Medicaid and SCHIP, but not enrolled due to State enrollment limits and budgetary pressures, and therefore frequently use emergency health services.

The Maternal and Child Health (MCH) Block Grant is operating for a second year with less funds than in fiscal year 2005, yet with greater needs among more pregnant women, infants, and children, particularly those with special health care needs. Furthermore, if programs like the Traumatic Brain Injury program, Universal Newborn Hearing Screening, and Emergency Medical Services for Children program are eliminated, those costs will be borne by the MCH Block Grant.

We are pleased with the increases proposed by the President for programs under the Ryan White CARE Act, administered by HRSA's HIV/AIDS Bureau. The CARE Act programs are an important safety net, providing an estimated 571,000 people access to services and treatments each year. At a time when HIV/AIDS is the sixth leading cause of death for people who are 25 to 44 years old in the United States, and the number of new domestic HIV/AIDS cases is increasing, we support increased funding for Ryan White Act programs.

Through its many programs and initiatives, HRSA helps countless individuals live healthier, more productive lives. As leaders of our Nation, this subcommittee decides what direction we will go in terms of delivering health care to those who need it most. The APHA believes that with adequate resources, HRSA is well positioned to meet these challenges as it continues to provide needed health care to the Na-

tion's most vulnerable citizens. We encourage the subcommittee to restore the funds to these important public health programs and reject the proposed cuts in the President's budget.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

We request a funding level of $440 million for the AHRQ for fiscal year 2007, an increase of $121 million over the enacted fiscal year 2006 level. This level of funding is needed for the agency to fully carry out its congressional mandate to improve health care quality, including eliminating racial and ethnic disparities in health, reducing medical errors, and improving access and quality of care for children and persons with disabilities. The cuts proposed in the administration budget will severely hamper these efforts.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

The APHA supports a funding level of $3.466 billion for SAMHSA for fiscal year 2007, an increase of $107 million over the enacted fiscal year 2006 level. This funding level would provide support for substance abuse prevention and treatment programs, as well as continued efforts to address emerging substance abuse problems in adolescents, the nexus of substance abuse and mental health, and other serious threats to the mental health of Americans.

NATIONAL INSTITUTES OF HEALTH (NIH)

The APHA supports a funding level of $29.75 billion for the NIH for fiscal year 2007, an increase of $1.1 billion over the enacted fiscal year 2006 level. The translation of fundamental research conducted at NIH provides the basis for community based public health programs that help to prevent and treat disease.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

The budget of the Office of Minority Health faced several years of decreasing budgets prior to last year. In fiscal year 2006, OMH received $56 million; and the proposed budget in fiscal year 2007 is $46 million. APHA is concerned that at a time when we have increasing evidence of disparities in health care delivery, access and health outcomes, the budget of OMH is getting cut. We support maintaining OMH funding at the fiscal year 2006 level.

CONCLUSION

In closing, we emphasize that the public health system requires financial investments at every stage. Successes in biomedical research must be translated into tangible prevention opportunities, screening programs, lifestyle and behavior changes, and other interventions that are effective and available for everyone. While we have said this before, in the post-September 11th era, we need to apply this to our spending growth in terrorism and influenza preparedness as well. We must think in a broad and balanced way, leveraging homeland security programs and funding whenever possible to provide public health benefits as a matter of routine, rather than emergency.

We thank the subcommittee for the opportunity to present our views on the fiscal year 2007 appropriations for public health service programs.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR CLINICAL PATHOLOGY

DEMAND FOR QUALIFIED LABORATORY PERSONNEL OUTSTRIPS SUPPLY

On behalf of the American Society for Clinical Pathology (ASCP), a non-profit organization representing 140,000 pathologists, medical technologists, cytotechnologists and other medical laboratory professionals, we are submitting this written testimony regarding the Title VII Allied Health Professions program that is administered by the Health Resources and Services Administration (HRSA).

Last year, funding for the Title VII Allied Health Professions program was cut by 68 percent. Funding for these programs, which provide seed money for the establishment and expansion of medical laboratory education training programs, was reduced from $300 million in fiscal 2005 to $94 million for the 2006 fiscal year. Funding for the allied health and other disciplines program was reduced from $11.8 million to $4 million. Congress eliminated funding for the allied health special project grants that fund medical laboratory education programs under the Title VII of the Public Health Service Act. These programs represent a small portion of the funding provided by the Labor, Health and Humans Services, and Education Appropriations

bill, but their importance to developing the next cadre of laboratory professionals can not be overstated.

Because few patients have direct contact with the people who work in our Nation's medical laboratories, the important role these health care practitioners play in patient care often goes unnoticed. Not only is laboratory testing key to diagnosing patient health, but laboratories also help identify appropriate patient treatments. In fact, the results of diagnostic laboratory testing impact over 70 percent of all healthcare treatment decisions. So, ensuring that our Nation's laboratories possess the laboratory professionals needed to accurately process laboratory testing demands is critical to patient health.

Unfortunately, the United States continues to face a severe shortage of qualified laboratory personnel. The U.S. Department of Labor projects that approximately 15,000 medical laboratory professionals will be needed each year through 2014. Unfortunately, fewer than 5,000 individuals are graduating each year from accredited or approved educational training programs.

Hardest hit by the shortage are rural areas and areas served by smaller hospitals. These areas are finding it increasingly difficult to recruit and retain qualified laboratory personnel. According to data gathered by the American Society for Clinical Pathology, half of all medical laboratories are reporting substantial difficulties hiring new testing personnel. It can often take a laboratory 6 to 12 months to hire an employee.

Another cause for concern is the average age of the laboratory workforce, which has been increasing steadily over the past few years, reflecting the fact that the pace with which younger, newly trained laboratorians have entered the laboratory workforce has not kept pace with retirements. At 43.7, the average age of medical technologists is essentially the same as that of nurses (43.3). An aging workforce can be more vulnerable to the adverse health and safety risks associated with shift work. Moreover, as our Nation ages, estimates project that the demand for laboratory testing services may increase.

Personnel turnover is also an increasing problem. With competition for laboratory personnel intensifying over the last year, turnover rates for some categories of laboratory personnel exceed 20 percent. Because of the difficulty in finding qualified staff, medical laboratories are increasingly turning to temporary staff (many of whom may already be working full- or part-time at another medical laboratory) to handle the patient testing workload.

To make matters worse, our Nation's capacity to train new laboratory personnel has declined substantially over the past 10 years. According to the National Accrediting Agency for Clinical Laboratory Sciences, school closings in the last 5 years have reduced the number of medical technologists and medical laboratory technicians being trained annually. The number of individuals graduating from these educational programs has declined approximately 35 percent over the last 10 years, from 6,783 graduates in 1994 to 4,390 in 2004. Over the last 10 years, the number of educational programs for laboratory professionals has declined more than 30 percent, from 637 programs in 1994 to 435 programs in 2004. For cytotechnologists, the number of educational programs has been reduced 25 percent over the last 10 years, from 65 programs in 1994 to 49 programs in 2004. Only 260 cytotechnologists graduate from these educational programs each year. Now with the devastating cuts to the Title VII programs, more programs may close.

Besides reducing our ability to train new laboratorians quickly, these losses have an especially profound impact on rural areas, where prospective laboratory practitioners often seek training close to home. Wyoming, for example, has no accredited or approved medical laboratory educational programs. Not surprisingly, data provided by HRSA indicates Wyoming has one of the lowest concentrations of laboratory professionals per resident (66 per 100,000 residents) in the United States.

ASCP believes that the Title VII Allied Health Education Programs have helped make a difference. For example, the University of Nebraska has for several years now offered a medical laboratory education program that has received funding under the allied health and other disciplines program. The University's program includes an effective distance training program that has served other nearby States as well. HRSA data indicates Nebraska has more than 128 laboratory professionals per 100,000 residents—almost twice the number of Wyoming and one of the highest concentrations of laboratory personnel in the United States. Because of cuts to the Title VII programs, Federal funding for the University of Nebraska's medical laboratory education program has been eliminated.

Given that medical technologist and medical laboratory technician jobs have often been ranked among the best jobs by the Jobs Rated Almanac, we hope increasing funding for laboratory professionals education programs will help encourage more individuals to pursue rewarding careers in the medical laboratory. Your help in re-

storing funding for these important educational programs will make our shared goal of reversing the laboratory personnel shortage much more obtainable. ASCP joins with our colleagues in the Health Professions and Nursing Education Coalition to request that Congress appropriate $550 million for the Title VII programs.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR MICROBIOLOGY

The American Society for Microbiology (ASM) is pleased to submit the following statement on the fiscal year 2007 appropriation for the National Institutes of Health (NIH). The ASM is the largest single life science Society with over 42,000 members who are involved in basic biomedical research, research and development activities, and diagnostic testing in university, industry, government and clinical laboratories.

The ASM is deeply concerned that the President's proposed fiscal year 2007 budget falls far short of adequately funding biomedical research supported by the NIH. Under the President's fiscal year 2007 budget request, 18 of the 19 Institute budgets are reduced in real dollars. These proposed reductions come at a time when more, not less, research is needed to address pressing health problems. Funding for the NIH in recent years has fallen substantially in constant dollars, foreshadowing a troubling future for biomedical research and for progress against health challenges from emerging and entrenched infectious diseases and chronic diseases. The continued toll on human life from chronic diseases, new threats from pandemic diseases and the potential dangers from bioterrorism make the ASM firmly believe that now is not the time to perpetuate the decline in funding of the past three fiscal years for the NIH. Biomedical research supported by the NIH is critical to the discovery of new knowledge and understanding which underpins development of medical treatments and vaccines. As the U.S. population ages and as global stability is threatened by pandemics, basic research which can only be supported by the NIH is essential to the well being of the world. However, basic biomedical research and the recruitment and training of the next generation of researchers will be weakened if funding for the NIH stagnates and does not keep pace with inflation for a fourth year.

The ASM commends Congress for the past decades of substantial and sustained funding for the NIH, an investment which is key to global health and benefits all Americans medically and economically. The ASM is pleased that the Senate recently has taken steps to increase the NIH budget for fiscal year 2007. The ASM urges Congress to continue to recognize the medical, economic, and strategic importance of adequately funding the NIH and recommends at least a 5 percent increase for the NIH in fiscal year 2007, an appropriation of $29.75 billion. This level of funding is the minimum amount necessary to sustain the current rate of research progress and offset biomedical research inflation.

BIOMEDICAL RESEARCH BENEFITS PUBLIC HEALTH PREPAREDNESS AND THE ECONOMY

In the past year, there have been tragic reminders that being unprepared protects neither the public health nor the economic and strategic interests of the United States. Increased support for biomedical research is needed because new knowledge and technology are the pillars of preparedness against biological threats. Each day we face local, national, and global threats to health, safety, and well-being. To counter these threats, the NIH's resources are focused on preserving and improving health in this country and elsewhere through innovative, cutting-edge research. Declining cancer, heart disease and stroke mortality, extended HIV/AIDS life expectancies, and massive genome databanks are evidence of the power of biomedical research. Research supported by the NIH is responding to the realities of 21st century medicine, developing predictive and preemptive medical capabilities to overcome expected health resource shortages and unforeseen dangers like newly identified microbial pathogens.

Research funded by the NIH also contributes to the Nation's competitiveness and economic strength, which is clearly rooted in basic science that generates commercially viable products and technologies. Biomedical research advances scientific knowledge, expands the high-technology workforce of the Nation, and enhances innovation among the country's private sector companies. Roughly 84 percent of the proposed fiscal year 2007 NIH budget will support the extramural science community through research grants and contracts. This funding will sustain work by more than 200,000 research personnel affiliated with approximately 3,000 hospitals, universities, private companies, and other research facilities.

INFECTIOUS DISEASE RESEARCH NEEDS INCREASED SUPPORT

Inadequate increases in funding for biomedical research weakens our national defenses against infectious diseases, which despite some medical victories persist as the second leading cause of death worldwide, accounting for 26 percent of all deaths. Infectious diseases particularly affect years of healthy life lost because they cause approximately two-thirds of deaths among children less than 5 years of age. Our ability to combat infectious diseases depends on basic research of how microbes spread, how they are harbored in the environment, and how they cause disease. The National Institute of Allergy and Infectious Diseases (NIAID) supports research that is essential to developing strategies to prevent, diagnose and treat infectious diseases here and abroad. NIAID funding supports both intramural and extramural researchers in academia and the private sector searching for new therapies, diagnostics, vaccines, and other technologies that improve health care for infectious diseases. This critical work also focuses on high-priority homeland security initiatives, includes influenza preparedness and counter-bioterrorism. Unfortunately, the proposed fiscal year 2007 budget leaves funding for the NIAID flat, about $4.4 billion or 0.3 percent over the fiscal year 2006 appropriation. With additional resources the NIAID could fund more promising initiatives and restore funding for research projects.

THE THREAT OF PANDEMIC INFLUENZA

Biomedical research and preparedness save lives and, in the case of pandemic influenza, the number of lives saved could be significant. Anticipating dire possibilities if the H5N1 avian influenza virus mutates sufficiently to move easily from human to human, the Department of Health and Human Services (DHHS) and other Federal agencies recently introduced the National Strategy for Pandemic Influenza. The ASM commends this plan as a prudent response to what could become a lethal global event. Fearsome pandemics have ravaged human populations three times in the past century: the 1918–1919 Spanish influenza that took more than 40 million lives worldwide, the 1957 Asian influenza, and the 1968 Hong Kong influenza. Those unusually virulent viral strains contained genetic material from avian influenza viruses like the current H5N1 virus. Confirmed reports of H5N1 related deaths in birds and mammals are coming from an expanding list of nations, where millions of domestic and wild fowl have died or been destroyed. In just the 4 months since the introduction of the National Strategy for Pandemic Influenza, H5N1 has spread to 37 nations. At present about 186 humans have contracted the disease, more than half of whom have died. Feared for their facile ability to infect and kill, influenza viruses are always with us. Every year, seasonal influenza causes 250,000 to 500,000 deaths worldwide. In the United States, this highly communicable disease annually causes an average 36,000 deaths, more than 200,000 hospitalizations, and, when calculated with pneumonia, an estimated $37.5 billion in direct and indirect costs. Together influenza and pneumonia are the leading infectious cause of deaths in the United States, ranked seventh among all causes of death. The Centers for Disease Control and Prevention has estimated that if pandemic flu arrives in the United States, 90 million people will become ill and almost 2 million people could die. The global potential for profound loss, millions of human lives and billions in financial costs, clearly demands that our public health institutions be ready with the most effective preventive and therapeutic measures against influenza.

The ASM strongly supports the critically important NIH influenza initiatives. Researchers sponsored by the NIAID are focusing on effective vaccines and antivirals as prioritized in the national strategic plan, which calls for pandemic vaccine within 6 months of detection, as well as enough antiviral treatment. Scientists supported by the NIAID have completed a successful clinical trial of an experimental inactivated H5N1 influenza vaccine. Research efforts in the DHHS Plan also include the development of new vaccine delivery systems and higher capacity cell-based production methods. Recent advances supported by the NIAID include the institute's Influenza Genome Project, collecting to date the full genomic sequences of more than 830 influenza viral isolates from human patients and building a repository databank for use by other scientists.

PROGRESS AGAINST INFECTIOUS DISEASES

There are numerous research programs at the NIH that battle a long and growing list of infectious diseases which deserve increased support. Biomedical research consistently yields new ways to treat or prevent diseases. The following are just a few examples of new science advances:

Scientists supported by the NIAID have collaborated to develop a tissue culture cell system in which the whole hepatitis C virus can be grown, which will allow researchers to better understand how Hepatitis C Virus (HCV) replicates and causes infection. HCV is a major cause of chronic liver disease with over 170 million infected people worldwide and can progress to cirrhosis of the liver, leading to liver cancer and failure. Two studies by the NIAID have shown that anti-cancer drugs show promise as potential antiviral drugs and merit further exploration. A vaccine to protect adults and adolescents against illness due to *Bordetella* pertussis infection, or whooping cough, has proved more than 90 percent effective in a large-scale clinical trial, which could help stem the increase in pertussis cases in the United States. The NIAID has supported a clinical trial of a vaccine against pneumococcal disease, which is a major cause of illness and death in children worldwide.

Biomedical research must remain focused on major killers like HIV/AIDS, tuberculosis and malaria, which together are responsible for more than 5 million deaths each year. Despite extensive prevention programs, an estimated 14,000 people are newly infected with HIV daily. Twenty-five years after physicians first described AIDS as a new disease, more than 40 million people are living with HIV. The bacterium that causes TB currently infects about one-third of the world's population. Multi-drug resistant (MDR) TB increased 13.3 percent in the United States from 2003 to 2004, the largest single year increase in MDR TB since l993, presenting significant challenges to treatment and control of TB in the United States and abroad. Extensively drug-resistant (XDR) TB has increased in the industrialized nations from 3 percent of MDR TB cases in 2000 to 11 percent in 2004. Two new engineered TB vaccines developed with support of the NIAID have entered clinical trials and a number of TB drug candidates are ready for clinical testing. Scientists continue to pursue a wealth of genomic data to understand malaria pathogenesis and to uncover new molecular targets for both drugs and vaccines for malaria which has an incidence of 300 to 500 million cases a year.

The NIAID funds extensive, multifaceted programs focused on these devastating diseases. In the past year, advances include: the new Center for HIV/AIDS Vaccine Immunology to address what is proving to be the very difficult task of finding HIV vaccines, with clinical sites in England, Africa, and three U.S. States; a clinical trial of two topical microbicides to assess effectiveness in stopping HIV transmission; and detection of a cellular protein that helps the tuberculosis microbe resist standard antimicrobials.

EMERGING DISEASES AND BIODEFENSE RESEARCH

A world influenced by rapid transit and global markets challenges not just U.S. competitiveness, but also our public health networks and our national sense of security. We no longer can view far-flung disease outbreaks as remote or theoretical threats to our well-being. The administration has requested $1.9 billion in fiscal year 2007 funding for the NIH's biodefense efforts in recognition that the ability to counter bioterrorism depends on progress in biomedical research and the support of scientific capacity to respond to new biological threats. In 2005, the NIAID awarded two additional grants to research consortia aimed at new vaccines, therapies, and diagnostics, completing a national network of 10 Regional Centers of Excellence for the NIAID Biodefense and Emerging Infectious Diseases Research program. Research targets include anthrax, plague, smallpox, West Nile fever, botulism, hantaviruses, viral hemorrhagic fevers and many other less-common diseases. The NIAID also began clinical trials of an experimental DNA vaccine against the West Nile virus, which first appeared in the United States in 1999; two NIAID-supported teams identified how Nipah and Hendra viruses attack human and animal cells, both emerging viruses that cause serious respiratory and neurological disease; and NIAID researchers and their university partners determined which host-cell enzymes Ebola viruses can hijack to infect humans.

CONCLUSION

To sustain the pace of research discovery, we must continue to enhance the research capacity and productivity of the Nation's biomedical research enterprise. We must be prepared for the predictable diseases and build sufficient research capacity to detect and respond quickly to unexpected health threats. The 2002–2003 outbreak of Severe Acute Respiratory Syndrome (SARS) is a prime example of this balance, a rapid international response occurred to the sudden reality of a novel pathogen, which spread to more than two dozen countries. Biomedical scientists drew upon vast reserves of earlier viral research and quickly developed three distinct SARS vaccines now being evaluated, with the first human clinical trial opening just 21 months after SARS appeared as a new disease. Increased funding for biomedical

research will strengthen our public health preparedness, our technological competitive edge and our ability to improve the quality and length of life for people. We urge Congress to provide at least a 5 percent increase for the NIH budget for fiscal year 2007 to help accomplish these goals.

PREPARED STATEMENT OF THE AMERICAN SOCIETY FOR MICROBIOLOGY

The American Society for Microbiology (ASM) is submitting the following statement in support of increased funding for the Centers for Disease Control and Prevention (CDC) in fiscal year 2007. The ASM is the largest single life science society with over 42,000 members who are involved in research and diagnostic testing in university, industry, government and clinical laboratories.

The fiscal year 2007 budget request would reduce funding for the CDC for the second year in a row. Excluding one-time emergency funding items, CDC core programs would be cut over 4 percent below the fiscal year 2006 level of funding, which was 4 percent below the fiscal year 2005 budget. In view of the CDC's critical role in protecting the health and safety of the public, the cumulative two year reduction of funding of over 8 percent is cause for serious concern. The ASM recommends that Congress provide $8.5 billion plus sufficient funding for pandemic influenza preparedness for the CDC in fiscal year 2007. This level of funding will sustain core programs crucial to improving public health in the United States and overseas.

The CDC works with partners in the United States and across the globe to monitor health status and trends, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound health policies, and foster safe and healthy environments. CDC capabilities must expand, not contract, as increasing worldwide connectivity brings global health concerns to the United States. Among the CDC's health protection goals are "people prepared for emerging health threats" and "healthy people in a healthy world." Both will require continued, extensive efforts here and abroad and clearly need sustained funding to assure success.

CDC PREPAREDNESS

CDC leadership in public health requires readiness to respond to unexpected health crises, above and beyond the Agency's ability to guard day-to-day wellness of people. In fiscal year 2005, the CDC's Epidemic Intelligence Service (EIS) officers responded to 66 health outbreaks, eight of them in other countries, and personnel from the CDC assigned to State or local health departments conducted 367 field investigations. After Hurricane Katrina struck the Gulf Coast, the CDC quickly provided information critical to preserving health and created the Katrina Information Network, later called the Emergency Response Information Network. Within two weeks, the CDC posted nearly 200 pertinent documents on its website (on infection control, first responder and volunteer safety, environmental issues and more). A commercial test kit for mold contamination, developed in 2003 by scientists of the CDC and a private biotech company, became a valuable assessment tool post-Katrina. Calls to the agency for rapid response generally involve infectious diseases, which persist as a principal concern of the CDC.

PANDEMIC INFLUENZA

Within the proposed fiscal year 2007 budget, pandemic influenza is a top-priority for funding for the CDC. The requested $188 million for pandemic preparedness would expand the CDC's participation in the Federal interagency National Strategy for Pandemic Influenza, the Federal agency plan to prevent, detect, and treat outbreaks of influenza. Since mid-2005, a virulent avian influenza virus (strain H5N1) has been moving more rapidly from nation to nation, killing millions of wild and domestic birds and causing concern that viral mutations might cause human-to-human transmission. Scientists recently found that the human virus strains responsible for three major pandemics in the 20th century contained genetic material derived from avian viruses. Thus far, human deaths from H5N1 have been relatively few, but those known to be infected suffer a high mortality rate. Globally, traditional seasonal influenza already kills 250,000 to 500,000 each year; pandemic influenza could kill many millions. Although the H5N1 virus has not reached the United States, many health officials consider future outbreaks in this country to be inevitable. If viral mutations provoke a human pandemic, 15–35 percent of the U.S. population could be affected, exacting a large number of influenza deaths and economic losses of $71.3–$166.5 billion, according to the CDC's estimates.

The proposed fiscal year 2007 funding for pandemic preparedness will continue fiscal year 2006 improvements in domestic disease surveillance, upgrades of quar-

antine stations at major ports of entry, and support of global surveillance and detection activities in endemic, epidemic, and other high-risk countries. The proposed budget would fund new resources to increase stocks of diagnostic reagents; establish laboratory facilities with appropriate biocontainment capabilities; develop models and risk-assessment tools to predict disease spread; increase seasonal flu vaccine production; establish a viral-genome reference library; and create an electronic registry to more effectively track, distribute and administer vaccines to the public. The CDC would conduct studies that examine human infections of animal influenza A viruses; an additional $2.8 million would streamline outbreak response in countries identified as needing special assistance; and nearly $20 million would help States administer more seasonal influenza vaccines and thus stimulate greater vaccine production by manufacturers.

In the past year, Federal support for the CDC's influenza preparedness activities yielded promising testing and vaccine development innovations. Researchers developed a laboratory test to diagnose currently circulating A/H5 (Asian lineage) strains of influenza in patients, which was approved this February by the Food and Drug Administration. Using advanced molecular technology, the test gives preliminary results within four hours, compared to two to three days with previous testing. To more rapidly detect U.S. influenza outbreaks, the test is being distributed to laboratories within the national Laboratory Response Network (LRN), facilities in all 50 States with special training in molecular testing, biosafety, and containment procedures. The CDC also shared the new testing technology with the World Health Organization (WHO); the CDC is one of four WHO Collaborating Centers worldwide providing technical and logistical expertise on pandemic influenza. Using new genetic sequence information, scientists from the CDC also collaborated last year with Federal and academic researchers to reconstruct the virus responsible for an estimated 20 to 50 million people during the 1918–19 pandemic. The virus particles are being stored at the CDC, for use in expedited vaccine and antiviral drug development.

INFECTIOUS DISEASES

To protect public health, the CDC has a major responsibility for preventing and controlling infectious diseases, still a leading cause of death and disability in this country and worldwide. The ASM is particularly aware of the important role of the CDC in protecting against infectious diseases. The fiscal year 2007 budget request includes $245 million for infectious disease programs, from laboratory research and epidemic investigations to surveillance networks, public education programs and specialized training. Increased funding for infectious diseases is needed not only to maintain and expand funding for existing infectious disease problems, but also to respond to new infectious disease threats and emergencies. The CDC must be able and ready to respond to shifting challenges, as it has done in the past for emerging disease outbreaks. The public clearly expects and relies on the CDC for rapid response to disease threats and for accurate, science-based advice on health issues. After the agency consolidated all of its more than 40 health information hotlines and clearinghouses into one toll-free service last March, the consumer center handled nearly 500,000 calls during its first 9 months and continues to expand.

Preventing and controlling serious infectious diseases in the United States depends on the CDC's scientific expertise and education outreach tailored for specific diseases. An example is the CDC program to prevent HIV/AIDS, sexually transmitted diseases, and tuberculosis, an ongoing multi-faceted effort that is allotted $1.0 billion in the administration's fiscal year 2007 request ($86 million more than fiscal year 2006). Tuberculosis continues to be a serious threat in the United States and worldwide, with a 13.3 percent increase in multi-drug resistant (MDR) TB in the United States from 2003 to 2004, the largest single year increase in MDR TB since 1993. An estimated 40,000 individuals newly acquire HIV in the United States each year and far more effort to prevent new infections is needed. The prevalence of anti-retroviral resistance to therapy at the time of HIV diagnosis is also increasing rapidly and will result in dramatically increased morbidity and health care costs if more effective efforts at prevention are not implemented. In contrast, new pediatric HIV infections are decreasing in number and routine prenatal HIV testing planned by the CDC for fiscal year 2007 should decrease pediatric cases even further. The CDC's National Plan to Eliminate Syphilis, started in 1999, requires further support with syphilis rates among U.S. men unfortunately increasing in the United States.

Preventive health in the United States met a major milestone last year, when government efforts finally eliminated rubella virus, the highly contagious agent of childhood measles. The ASM agrees with the CDC's fiscal year 2007 budgetary em-

phasis on vaccination, certainly one of the most efficient and effective methods to fight infectious diseases. The fiscal year 2007 $2.6 billion immunization program continues two established components to protect the Nation's children, the Vaccines for Children program that provides vaccines free to children in financial need (40 percent of all childhood vaccines purchased in the United States), and the Section 317 program, supporting State-managed immunization programs. Researchers from the CDC recently used computer modeling to evaluate economic benefits from this country's standard childhood immunization schedule, comprising seven vaccines for illnesses like diphtheria, mumps, and polio. They concluded that collectively the immunizations not only save thousands of lives each year, but also $10 billion in direct medical costs plus more than $40 billion in indirect costs.

The CDC's protection of American health and safety reaches beyond national borders, facing infections that can migrate from one afflicted population to the next through global travel and commerce. International collaboration against pandemic influenza is a large-scale example, but one among many such responses. Last year, experts from the CDC worked with officials from the WHO and the Angola government to control an outbreak of Marburg hemorrhagic fever in that African nation, posting traveler alerts on its website and providing on-site laboratory and field investigative services.

The proposed fiscal year 2007 budget requests $381 million for the CDC's global health activities, to improve detection and control of diseases such as HIV/AIDS, malaria, polio, and measles. In fiscal year 2005, the CDC program Preventing Mother-and-Child HIV Transmission collaborated with other nations to screen 2 million pregnant women in 15 countries, giving short-course antiretroviral prophylaxis to 125,000 who tested HIV-positive. The fiscal year 2007 budget includes $122 million in direct AIDS-related funding for ongoing prevention, treatment, and surveillance in 25 countries. From 1988 to 2004, global polio incidence declined by more than 99 percent, saving about 250,000 lives and avoiding 5 million cases of childhood paralysis. Global deaths due to measles fell by 48 percent between 1999 and 2004.

The National Laboratory Training Network (NLTN) is a unique training system sponsored by the CDC and the Association of Public Health Laboratories. The NLTN is solely dedicated to ensuring quality laboratory practice for testing of public health significance through relevant and timely continuing education offered in a variety of educational venues at a reasonable cost, often at no charge. The NLTN Continuing Education programs offer laboratories critical insights into public health needs while also ensuring high quality, cost-effective, and clinically relevant direct patient testing needs are met. The ASM strongly supports the continuation of the NLTN programs though the CDC.

BIOTERRORISM

The possibility of bioterrorism persists as a principal focus for the CDC, and the fiscal year 2007 budget requests $1.7 billion to support ongoing programs, the Strategic National Stockpile (SNS), surveillance and quarantine efforts, laboratory research on high-risk pathogens like anthrax, and assistance to State and local governments. Since its creation in 1999, the SNS has expanded its inventory of vaccines, drugs, and other countermeasures, preparing for health crises like influenza pandemics, natural catastrophes like Hurricane Katrina, and biological, chemical, radiological, or nuclear terrorist attacks. Supplies can be delivered anywhere in the United States within 12 hours of an event. The SNS fiscal year 2007 request of $593 million increases the fiscal year 2006 appropriation by $70 million, nearly $50 million of which will finance portable hospital units under the Mass Casualty Initiative, for rapid deployment to expand local hospital capacity. The CDC's fiscal year 2007 bioterrorism strategy also includes funding to utilize a recent invention, a new mass spectrometry method from the CDC's Environmental Health Laboratory for detecting botulinum toxin in people and the Nation's milk supply within 15 seconds. The additional funds will improve the method to more rapidly detect anthrax lethal factor, ricin and other toxins that can be used as bioweapons, as well as fully exploit the method's "fingerprinting" of suspect toxins to determine their source.

The ASM asks Congress to recognize and support the CDC's crucial activities by providing increased support for the CDC's core programs and pandemic influenza preparedness.

PREPARED STATEMENT OF THE AMERICAN SOCIETY OF NEPHROLOGY

INTRODUCTION

The American Society of Nephrology (ASN) is pleased to submit this statement for the record to the Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education in support of the ASN's top funding and research priorities for fiscal year 2007.

The ASN is a professional society of more than 10,000 researchers, physicians, and practitioners who are committed to the treatment, prevention, and cure of kidney disease. Specifically, the ASN is committed to enhance and assist the study and practice of nephrology, to provide a forum for the promulgation of research, and to meet the professional and continuing education needs of its members.

The ASN statement focuses on those issues and programs that most immediately fall under the committee's jurisdiction and assist our members to fulfill their missions. We want to express our strong support for advancing programs supported by the National Institutes of Health (NIH) and Agency for Healthcare Research and Quality (AHRQ). The ASN thanks the subcommittee for its commitment and steadfast support of these programs.

THE FACE OF KIDNEY DISEASE

Kidney disease is a major health problem in the United States, and along with Alzheimer's disease, the fastest growing cause of death in the United States. (CDC data). It is estimated that at least 15 million people have lost 50 percent of their kidney function without even knowing it and suffer from Chronic Kidney Disease (CKD). Another 20 million more Americans are at increased risk of developing kidney disease. Sub clinical kidney disease has emerged recently as a major risk factor for CVD. The culmination of unimpeded progression is end stage renal disease (ESRD), a condition in which patients have permanent kidney failure, affects almost 400,000 Americans, and directly causes 50,000 deaths annually. In the past 10 years, the number of patients in the United States with ESRD has almost doubled. Although the largest age group having ESRD ranges from 45–64 years old, rates increase steadily for those between the ages of 65–74 and are disproportionately high in African-Americans. African-Americans represent about 32.4 percent of all patients treated for kidney failure in the United States and the risk of ESRD for middle-age African-American males with high blood pressure is six times that of their Caucasian counterparts.

ECONOMIC COSTS

Although no dollar amount can be affixed to human suffering or the loss of human life, economic data can help to identify and quantify the current and projected future financial costs associated with ESRD. The 2000 report of the United States Renal Data System indicates that the total Medicare ESRD program cost will more than double, surpassing $28 billion, by 2010, as the prevalence of kidney failure is projected to double. The annual average cost per ESRD patient is approximately $55,000. These escalating costs serve to magnify the need to investigate new, and better apply, recently proven strategies for preventing progressive kidney disease.

In short, we can treat and maintain patients who have lost their kidney function but the critical need is to prevent the loss of kidney function and its complications in the first place. Meeting this vital goal can only be accomplished through more concerted research and education.

MAJOR CAUSES OF END STAGE RENAL DISEASE

Diabetes, a disease that affects 17 million Americans, is the most common cause of ESRD in the United States. Nearly 34 percent of all Americans being treated for kidney failure have diabetes. Moreover, only 18 percent of people with diabetes survive 5 years after beginning treatment for kidney failure. With current projections that the epidemic of obesity-related diabetes mellitus will continue to soar, a dramatic increase in kidney disease is anticipated in the next 10 years.

Hypertension, or high blood pressure, is the next leading cause of ESRD, accounting for 23.6 percent of ESRD patients. Similar to diabetes, higher rates of hypertension can be found among certain age and ethnic groups. For example, hypertension is common among African-Americans (35 percent). It is also a disease of the aged and accounts for 37 percent of new ESRD cases in those 65 years old and above.

Despite recent progress and discoveries regarding the major causes of ESRD, it is among many areas of disease research that remain under-investigated. Research-

ers agree that significant inroads in previously understudied sub-fields need to be made. Significant among them, more focus and direction need to be introduced into the general field of renal research and patient and physician education. These pressing factors provided the impetus for an informal dialogue on the resulting calls to action.

LACK OF PUBLIC AWARENESS

A major problem with kidney disease is that it is largely a "Silent Disease". In fact, of the 15 million Americans who have lost at least half of their kidney function, the vast majority have no knowledge of their condition. While people with chronic kidney disease may not show any symptoms, this does not mean that they are not going to have long-term damage to their kidney function, requiring dialysis or a transplant. These people may also be especially vulnerable to cardiovascular disease. If these 15 million people were identified early, there are new therapies, particularly special blood pressure drugs known as ACE inhibitors, which could be prescribed with potentially significant benefits. In addition, vigorous treatment of hypertension and other complications that cause illnesses and loss of productivity could be administered to the patients.

Given the cost to human life and to the Federal Government caused by ESRD specifically, as well as other forms of kidney disease, we urge this subcommittee to provide funding increases for kidney disease research.

KIDNEY DISEASE RESEARCH

National Institutes of Health (NIH)

The ASN applauds Congress and members of the subcommittee for leading the bipartisan effort to double our investment in promising biomedical research supported and conducted by the NIH. NIH has served as a vital component in improving the Nation's health through research, both on and off the NIH campus, and in the training of research investigators, including nephrology researchers. Strides in biomedical discovery have had an impact on the quality of life for people with kidney disease. If we are to sustain this momentum and translate the promise of biomedical research into the reality of better health, this Nation must maintain its commitment to medical research. We support the recommendation of the Ad-Hoc Group for Medical Research Funding to add 5 percent in fiscal year 2007 to the NIH budget for a total of $29.750 billion.

In fiscal year 2007, the NIH budget must grow by 3.5 percent, or nearly $1 billion, just to keep pace with inflation. Further, the NIH has ambitious plans for new initiatives to combat the health challenges of the future. To ensure that NIH's momentum is not further eroded, and to continue the fight against the diseases and disabilities that affect millions of Americans, the ASN will work with the administration and the Congress to seek an NIH budget of at least $30 billion for fiscal year 2007.

National Institute of Diabetes, Digestive, and Kidney Diseases (NIDDK)

Many recent advances have been made in our understanding into the causes and progression of renal failure, such as: how diabetes and hypertension affect the kidney and the mechanisms responsible for acute renal failure.

Despite these advances, the number of people with renal failure and the numbers who die of renal failure continue to increase each year. Most alarming is the significant increase in diabetes, the most common cause of chronic kidney failure, and its relationship to kidney disease. The ASN believes the rising incidence and prevalence of diabetes-related kidney disease warrants additional recourses to improve our understanding of the relationship between kidney disease and diabetes.

The NIDDK sponsors a number of activities that researchers hope will lead to improved detection, treatment and prevention of kidney disease and chronic kidney failure. To ensure ongoing kidney disease and kidney disease related research and important clinical trials infrastructure development we recommend a 5 percent increase for the NIDDK over fiscal year 2006 levels.

ASN RESEARCH GOALS & RECOMMENDATIONS FOR KIDNEY DISEASE

In the fall of 2004, the ASN conducted a series of research retreats to develop priorities to combat the growing prevalence of kidney disease in the United States. The ASN joined experts, both within and outside the renal community, and identified five areas requiring attention: acute renal failure, diabetic nephropathy, hypertension, transplantation, and kidney-associated cardiovascular disease.

The final research retreat report(s) highlighted priorities and contained three overriding recommendations. Theses include:

1. Development of Core Centers for kidney disease research

Expansion of the kidney research infrastructure in the United States can be achieved by vigorous funding of a program of kidney research core centers. Specifically, we propose that the number of kidney centers be increased with the goal of providing core facilities to support collaborative research on a local, regional and national level. It should be emphasized that such a program of competitively reviewed kidney core centers would facilitate investigator-initiated research in both laboratory and patient-oriented investigation. This approach is highly compatible with the collaborative research enterprise conceived in the NIH Road Map Initiative.

2. Support programs/research initiatives that impact the understanding of the relationship between renal and cardiovascular disease

It is now well recognized that chronic kidney dysfunction is an important risk factor for the development of cardiovascular disease. It is recommended that the NIDDK and NHLBI work cooperatively to support both basic and clinical science projects that will shed light on the pathogenesis of this relationship and to support the exploration of interventions that can decrease cardiovascular events in patients with CKD. Thus, we specifically propose that NHLBI should support investigator-initiated research grants in areas of kidney research with a direct relationship to cardiovascular disease. Similarly, NHLBI should work collaboratively with NIDDK to support the proposed program of kidney core research centers.

3. Continued support and expansion of investigator initiated research projects

In each of the five subjects there are areas of fundamental investigation that require the support of investigator initiated projects, if ultimately progress is to be made in the understanding of the basic mechanisms that underlie the diseases processes. It is recommended that there should be an expansion of support for research in the areas that lend themselves to this mechanism of funding, by encouraging applications with appropriate program announcements and requests for proposals. In addition to vigorous support for RO1 grants, continued funding of Concept Development and R21/R33 grants is essential to support development of investigator-initiated clinical studies in these areas of high priority. Such funding is critical to accelerate the transfer of new knowledge from the bench to the bedside.

In summary, the ASN foresees the following important directions in the future of kidney disease research:

—Continued research in acute renal failure, diabetic nephropathy, hypertension, transplantation, and kidney-associated cardiovascular disease;
—The establishment of core centers for kidney disease research;
—Persistent attention to the relationship between kidney disease and hypertension and collaboration between NIDDK and NHLBI;
—Expansion of investigator initiated research projects.

The ASN will strive to fulfill its mission statement and research recommendations (agenda). The ASN will remain active on Capitol Hill and assist members of Congress and the administration in their understanding of kidney disease and problems facing CKD and ESRD patients and the health care providers who serve them.

Agency for Health Care Research and Quality (AHRQ)

Complementing the medical research conducted at NIH, the AHRQ sponsors health services research designed to improve the quality of health care, decrease health care costs, and provide access to essential health care services by translating research into measurable improvements in the health care system. The AHRQ supports emerging critical issues in health care delivery and addresses the particular needs of priority populations, such as people with chronic diseases. The ASN firmly believes in the value of AHRQ's research and quality agenda, which continues to provide health care providers, policymakers, and patients with critical information needed to improve health care and treatment of chronic conditions such as kidney disease. The ASN supports the Friends of AHRQ recommendation of $440 million for AHRQ in fiscal year 2007.

CONCLUSION

Currently, there is no cure for kidney disease. The progression of chronic renal failure can be slowed, but never reversed. Meanwhile, millions of Americans face a gradual decline in their quality of life because of kidney disease. In many cases, abnormalities associated with early stage chronic renal failure remain undetected and are not diagnosed until the late stages. In sum, chronic renal failure requires our serious and immediate attention.

As practicing nephrologists, ASN members know firsthand the devastating effects of renal disease. ASN respectfully requests the subcommittees' continued support to

enable the nephrology community to continue with its efforts to find better ways to treat and prevent kidney disease.

Thank you for your continued support for medical research and kidney disease research. To obtain further information about ASN, please go to http://www.asn-online.org or contact Paul Smedberg, ASN Director of Policy & Public Affairs at 202–416–0646.

PREPARED STATEMENT OF THE ASSOCIATION OF ACADEMIC HEALTH CENTERS

The Association of Academic Health Centers (AAHC) is pleased to submit this statement for the record with its fiscal year 2007 appropriations recommendations for a number of essential programs that are critical to improving health and health care delivery in our Nation.

The AAHC, the national organization representing almost 100 academic health centers, is dedicated to improving the Nation's health care system by mobilizing and enhancing the strengths and resources of the academic health center enterprise in health professions education, patient care, and research. An academic health center consists of an allopathic or osteopathic medical school, one or more other health professions schools or programs, and one or more owned or affiliated teaching hospitals, health systems, or other organized health care services. Our member institutions have enormous impact on their regions, the Nation, and the global economy.

THE RESEARCH ENTERPRISE

AAHC member institutions are the infrastructure of the Nation's research enterprise. Academic health center researchers in both the basic and clinical sciences are pushing the bounds of science to advance progress in the diagnosis and treatment of myriad diseases and chronic illnesses. In addition, our institutions are engaged in a broad range of health services research contributing to improvements in the organization, financing, and delivery of health services.

Our key partner in the nation's research achievements is the National Institutes of Health (NIH), which throughout its history has provided the necessary funding for basic science research and a wide array of projects to test clinical applications. Maintaining NIH's capabilities to carry out investigator-initiated research is absolutely critical to ensure that the Nation advances in health care, sustains the education and advancement of highly trained scientists, and builds the infrastructure for the conduct of research across the country. We believe that America's preeminence in science and its leading position in our global economy are tied closely to the Nation's investment in its research enterprise through the NIH.

Over the past 3 years, increases in appropriations for the NIH have not kept pace with inflation. In fact, the administration's current proposal to freeze the NIH budget at a level that is more than 11 percent below the 2003 funding level in constant dollars can only be viewed as threatening to the Nation. The practical effect of such funding is that NIH cannot sustain its ongoing efforts and at the same time support promising new research. The opportunity costs in terms of our capacity to reduce the burden of illness and improve patient outcomes are enormous. Disrupting ongoing research projects or failing to support promising new proposals is, in the long run, more costly than any short-term budget savings. The cost will be counted by the missed opportunities to mitigate or cure many conditions, reducing the quality of life for people throughout the world.

We believe that the Congress must renew its commitment to the research enterprise, even in these times of budgetary restraint. Failure to do so means that with each passing year the NIH will support less internal and extramural research. We are very pleased that the Senate Budget Resolution for fiscal year 2007 provides for a $7 billion increase in overall discretionary dollars for health and education programs, including an assumption of at least $1 billion for the NIH. We are very grateful for the leadership of Senators Specter and Harkin who proposed an amendment to increase funding and argued persuasively for making this investment in the future of biomedical research. We strongly recommend that funding for the NIH in fiscal year 2007 be increased at least 5 percent or no less than the funding provided in fiscal year 2005 to prevent further erosion of its purchasing power.

THE HEALTH PROFESSIONS WORKFORCE

The health workforce must be viewed as a cornerstone of our Nation's well being. The health professions not only treat and care for patients but also represent an economic engine for the country. Unfortunately, the supply of health professionals is threatened. By most estimates, there are an insufficient number of health profes-

sionals to meet current and future demands. It has been estimated that the Nation will need approximately 3.5 million health care workers in addition to the 2 million workers to replace those who leave the workforce.

Further, the geographic maldistribution of health professionals—especially primary care physicians and other non-physician practitioners—leaves large numbers of Americans without access to care with as many as 50 million people living in communities officially designated as health professions shortage areas. Of particular concern are estimated shortages in dentistry, medicine, nursing, pharmacy, and an array of allied health professionals that will likely increase with an aging population and potentially less migration of health professionals throughout the world.

The health and economic prosperity of the Nation depend on an effective and well-trained health workforce. Key to ensuring an adequate supply is investment in the educational programs and the students who are pursing careers in the health professions. Moreover, these educational programs need to increasingly attract students who will practice in underserved areas—both during their training and afterward. At the same time, continuing education and distance learning programs must be maintained to connect practitioners with advances in care and provide opportunities for consultation and referral. Strengthening the health care delivery system in underserved areas is key to our efforts to improve the health of the Nation and eliminate the disparities in health outcomes that result from inadequate access to care.

The cornerstone of efforts to address the maldistribution of health professionals, to train a diverse health professions workforce, and to promote access for elderly and other vulnerable populations has been the programs authorized under Title VII of the Public Health Service Act. These programs include targeted scholarships for disadvantaged students; initiatives at the secondary school level to prepare students for college-level programs in the allied health professions; direct support for programs in pharmacy, dentistry, geriatrics, pediatrics, and other primary care disciplines; and Area Health Education Centers and Health Education and Training Centers. In addition, Title VIII funds for nursing have been especially important in helping to address widespread and persistent shortages and to develop programs for much needed advanced practice nurses, including the faculty to direct these programs. Support for health professions programs has been unstable and, in the case of Title VII, was cut more than half this year—from $252 million in fiscal year 2005 to $99 million in fiscal year 2006.

It is also important to note that cutting support for health professions education is likely to undermine current efforts to significantly expand community health centers. Staffing for these centers relies on primary care practitioners in the disciplines that are the focus of many of the programs in Titles VII and VIII. A recent study published in The Journal of the American Medical Association (March 1, 2006; Vol. 295, No. 9) found that workforce shortages "may impede the expansion of the U.S. community health center safety net, particularly in rural areas." The study also recommends that funding for Title VII be bolstered as this is "the only Federal program that exists to encourage the production of primary care clinicians likely to practice in underserved areas . . ."

Reports from the member institutions of the AAHC confirm the adverse impact of further reductions in funding for Title VII. For example, at the University of Nebraska Medical Center, Title VII grants totaling $3.2 million were received in fiscal year 2005. These grants support the placement of behavioral health professionals in more than 140 rural and other underserved settings providing over 5,000 annual behavioral health visits.

In addition, the Nebraska Geriatric Education Center, supported by a Title VII grant, plays a key role in training professionals to meet the needs of older patients while at the same time expanding access to care for this population. Finally, the School of Allied Health and the primary care medicine programs at the University of Nebraska Medical Center depend on Title VII grants to increase the diversity of their student population and to provide teaching opportunities in sites serving rural and other underserved communities.

Without continuing support from Title VII grants, California health professions training programs could lose approximately $18 million annually. Statewide programs in California train physicians to work in underserved areas such as rural and inner city clinics, teach medical Spanish and cultural awareness skills to health professionals, and work with community health workers in low-income neighborhoods to teach self-help skills to patients with diabetes and asthma.

In North Carolina more than $12.5 million in Title VII grants were distributed to the University of North Carolina at Chapel Hill, Duke University, and Wake Forest University. These funds are used to train primary care physicians, dentists, geriatric specialists, physician assistants, and others. These programs have helped to recruit a diverse cadre of students as well as support the work of Area Health Edu-

cation Centers which are linked to the universities and provide essential access to care in underserved areas.

These are just a few examples of the valuable work that results from the Federal funding of Title VII. The administration's recommendations would virtually eliminate funding for these programs.

Leaders of academic health centers nationwide confirm that these programs have made a difference in the nation's health. The Nation's return on its investment is clear. Title VII has succeeded in (1) supplying a workforce to serve populations in need, (2) enabling institutions and communities to recruit a diverse workforce, and (3) expanding access to care for many of the Nation's most vulnerable individuals.

We strongly recommend that funding for Titles VII and VIII total $550 million for fiscal year 2007. This would help to off-set the $155 million cut in place for this year and ensure that these critical programs can continue to address the urgent need to improve the health of our Nation.

HOSPITAL PREPAREDNESS PROGRAM

The continuing threats from natural and/or terrorist events require our health system to be prepared to treat mass casualty events. Critical emergency care and inpatient surge capacity must be available across the country. Because of the financial condition of many public and non-profit hospitals, the cost of capital to undertake the necessary preparations for the treatment of large numbers of patients is beyond their reach. These funds make it possible for hospitals to build the infrastructure and surge capacity that is necessary to meet unknown, but potentially large, public health emergencies.

We strongly support the administration's budget request for $474 million for the hospital preparedness program to continue progress toward a more rapid and coherent response to these unpredictable circumstances.

STATE HIGH-RISK INSURANCE POOLS

The number of uninsured in America continues to grow as employers curtail or drop group coverage and many workers are forced to forego coverage. The AAHC has been at the forefront of efforts to address the crisis of the Nation's uninsured. This is an urgent problem and we are committed to supporting a range of approaches to make health coverage more accessible and affordable.

One subset of the uninsured population involves individuals at risk for health care coverage because of one or more pre-existing health conditions. Some of these individuals have only been able to purchase coverage under the auspices of State high-risk health insurance pools because no other insurance product is available to them. State high-risk insurance pools are a vital pathway for those who have been excluded from the health insurance market because of their health status.

Section 2745 of the Public Health Service Act authorizes a program of grants to the States for the establishment and operation of qualified high-risk health insurance pools. In the recently enacted Deficit Reduction Act, Congress extended this program and authorized $75 million for fiscal year 2007. Unfortunately, the President's budget does not recommend any funding for this important program. We urge the subcommittee to fund this grant program at the fully authorized amount of $75 million.

We thank you for the opportunity to present our views and recommendations regarding funding for discretionary health programs in fiscal year 2007. Our member institutions are committed to improving the Nation's health and well-being, and we look forward to working with Chairman Specter and all members of the subcommittee. We are pleased to be available to provide information and answer questions at any time.

PREPARED STATEMENT OF THE ASSOCIATION OF AMERICAN CANCER INSTITUTES

The Association of American Cancer Institutes (AACI), representing 86 of the Nation's premier academic and free-standing cancer centers, appreciates the opportunity to submit this statement for consideration as the Labor-Health and Human Services Appropriations Subcommittee plans the fiscal year 2007 appropriations for the National Institutes of Health (NIH) and the National Cancer Institute (NCI).

AMERICA'S INVESTMENT IN CANCER RESEARCH

Thirty–five years ago, a diagnosis of cancer was largely a death sentence. Since then, our national investment in cancer research has reaped remarkable returns, including potential cancer vaccines, improved detection strategies, and targeted, less

difficult therapies. The last several years have been particularly exciting for science and specifically for cancer research. Advances such as the sequencing of the human genome and improved insights about the genetics of cancer have led to promising new approaches to the prevention and treatment of cancer. Today, many patients are benefiting from targeted drug therapies, like Gleevec, Tarceva and Avastin that are more specific, less toxic and more effective. It is the support of the Nation's cancer research enterprise by the NCI, 80 percent [1] of whose funds are spent at academic research institutions across the country, that has led to these discoveries.

The President's 2007 budget proposal provides only level funding for the NIH and a $40 million cut for the NCI. This is of great concern to the Nation's cancer centers, which play a critical role in the progress against cancer, and are major hubs of State of the art cancer research, drug development, treatment, prevention and control. A depleted budget for NCI directly impacts the pace of scientific discovery and may mean that new ideas to combat cancer will go unexplored, and the development of novel cancer therapies will be seriously compromised. Reduced funding will also discourage the next generation of cancer researchers leading some to choose other fields. We are at a time of unprecedented opportunity to make a dramatic assault on cancer, and the hard-won momentum that has been achieved in recent years must be sustained. Otherwise, America risks losing an entire generation of ideas that could produce possible cures for the diseases we know as cancer.

CANCER RESEARCH: SAVING LIVES AND MONEY

At the Nation's cancer institutes, we have demonstrated that cancer research saves lives. Cancer mortality rates decreased by 10 percent between 1991 and 2001, translating to as many as 321,000 lives saved [2] and in 2003, the number of cancer deaths dropped for the first time since the war on cancer began. The death rate for all cancers combined is dropping about 1.1 percent per year, while the rate of new cancers is holding steady.[2] The five-year relative survival rate for all cancers diagnosed between 1995 and 2000 is 64 percent, an increase from just 50 percent in the mid-1970s. Thanks to prevention research and the development of early detection technologies and new treatments, today, nearly 10 million Americans are cancer survivors.[2]

The financial cost of cancer is rising, but research advances help to mitigate cancer's annual price tag, which in 2005 was estimated at $210 billion, including $136 billion in lost productivity and over $70 billion in direct medical costs.[3] Tamoxifen, used to treat breast cancer, is saving $41,372 for each year of life gained in women 35 to 49 years old; $68,349 for women 50 to 59 years old; and $74,981 for women 60 to 69 years old.[4] The drug Cisplatin has translated to an increase in the survival rate for testicular cancer patients. The drug cost an estimated $56 million to develop and has already produced an annual return of $166 million in treatment savings.[5] That research saves money is evident.

THE NATION'S CANCER CENTERS: ECONOMIC ENGINES IN THEIR COMMUNITIES

In addition to training the future workforce for cancer care and research, America's cancer centers themselves have direct economic impact, both locally and nationally. It is estimated that every dollar spent on research funding and patient activities at cancer centers translates to $2.50 to $3 invested in the local economy.[6] In addition, the amount of research support and operating budgets that are leveraged through NCI-designated cancer centers support grant (CCSG) funding alone is striking. The total amount of research support is more than ten times the amount generated by the CCSG grants themselves.[7] By attracting patients from outside the community, constructing new laboratories and clinical facilities, recruiting new faculty and staff from outside the region who bring cutting-edge scientific, clinical and public health expertise to work in communities, and developing entrepreneurial op-

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[1] United States. Department of Health and Human Services. The Nation's Investment in Cancer Research. 2006. (http://plan.cancer.gov/pdf/nci__2007__plan.pdf)

[2] Statistics from the American Cancer Society.

[3] Estimates from the National Heart, Lung and Blood Institute.

[4] United States Senate. Joint Economic Committee, Office of the Chairman, Connie Mack. The Benefits of Medical Research and the Role of NIH. 2000. (http://jec.senate.gov)

[5] Estimates from Lasker/Funding First. (www.fundingfirst.org)

[6] United States. Department of Commerce, Bureau of Economic Analysis. Regional Multipliers: A User Handbook for the Regional Input-Output Modeling System (RIMS II). 3rd ed. 1997.

[7] United States. National Cancer Institute. Advancing Translational Cancer Research: A Vision of the Cancer Center and SPORE Programs of the Future. 2003. (http://deainfo.nci.nih.gov/advisory/ncab/p30-p50/P30-P50final12feb03.pdf)

portunities in the biotech and pharmaceutical industries, cancer research centers serve as an economic stimulus and generate commerce in their communities.

UNITED STATES: GLOBAL LEADER IN CANCER RESEARCH

The United States is a world leader in the battle against cancer because of the Nation's past investment in cancer research, but our competitive edge will quickly erode without continued commitment. Sustained inquiry and scientific advancement are critical to maintaining our competitive stature. Failure to appropriate new funds for biomedical innovation and discovery threatens America's capacity to compete with emerging global economies and other countries are eager to take our place as the world's leader in biomedical research. The United States must significantly enhance its research and technical capacity to maintain our preeminent position.

CONCLUSION

In summary, cancer research saves lives, saves money, stimulates economic growth at home and enhances U.S. competitiveness abroad. Federal investment in cancer research must remain a national priority. America must commit to sustaining the pace of cancer-related science so that new discoveries are translated into clinical benefit for all. Congress has the opportunity now to take an important leadership role in assuring that the NIH budget is increased in fiscal year 2007. We urge your support to increase this critically important funding.

PREPARED STATEMENT OF THE ASSOCIATION OF INDEPENDENT RESEARCH INSTITUTES

The Association of Independent Research Institutes (AIRI) respectfully submits this written statement for the record of the U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education. AIRI appreciates the commitment that the members of this Subcommittee have made to biomedical research through support for the National Institutes of Health (NIH).

AIRI is a national organization of 86 independent, not-for-profit research institutes that perform basic and clinical research in the biological and behavioral sciences in 28 States. Our member institutes are private, stand-alone research centers that set their sights on the vast frontiers of medical science. AIRI institutes—many of which were originally established by generous philanthropists or from spin-offs of unique university research areas—tend to be relatively small in size, with budgets ranging from a few million to hundreds of millions of dollars. In addition, each AIRI institution is governed by its own independent Board of Directors, which allows our members to be structurally nimble and capable of adjusting their research programs to emerging areas of inquiry. While the primary function of AIRI institutes is research, most are also strongly involved in training the next generation of biomedical researchers. In a testament to the quality of research and innovative ideas that AIRI institutes bring to the national biomedical enterprise—our institutions consistently exceed the success rates of the overall NIH grantee pool, and receive about 11 percent of NIH's peer reviewed, competitively awarded extramural grants.

The doubling of the NIH budget allowed the biomedical research community to accelerate solutions to human disease and disability. We have blazed new trails for medical research, diving into the intricacies of how the human body musters its defenses, and how those responses can be evaluated, enhanced, and modified. In addition, it helped us to realize new scientific management strategies such as fostering interdisciplinary research and creating new robust teams of scientists that, before the doubling, did not have scientific common ground. These research teams navigate the fast progressing research environment where there is an increasing need to integrate and aggregate basic research, computational capabilities, and clinical evidence into new cures more quickly. Further, the doubling has helped us to redefine health and healthcare goals based on scientific discoveries that were out of reach prior to the doubling. We now talk about disease and health care in terms of predictive, preventative and pre-emptive tactics.

With flexible structures that are friendly to change, AIRI institutes are able to move amongst the new science partnerships that will transform America's health and health care in the 21st century. NIH has responded to the rapidly changing world by strategically framing the next generation of biomedical research through cross-cutting, interdisciplinary initiatives such as those supported in the NIH Roadmap, the NIH Neuroscience Blueprint, the new Clinical and Translational Science Award program and the new Genes, Environment and Health Initiative. AIRI institutes are innovators poised to foster partnerships that will nurture the collaborative

environment necessary to successfully and efficiently conduct research within these evolving NIH frameworks.

AIRI endorses the fiscal year 2007 Ad Hoc Group for Medical Research proposal to increase the NIH budget by five percent over the fiscal year 2006 level. We recognize that the current budget environment puts pressure on Congress to face difficult funding trade-offs; however, as this subcommittee works to define priorities for the year and set goals for the future, AIRI asks that you maintain your long-term commitment of support for NIH and its mission. The President's fiscal year 2007 budget would flat-fund NIH. The 5 percent increase for NIH supported by AIRI would not only allow the agency to sustain current programs but also invest in critical new initiatives. This would prevent NIH from falling behind the "Innovation Index"—the rate of biomedical inflation as calculated in the Biomedical Research and Development Price Index (BRDPI) plus a modest investment in new initiatives.

Using the fiscal year 2007 BRDPI projection as a base, NIH would require an increase of at least 3.8 percent over fiscal year 2006. AIRI strongly believes that an increase for NIH above BRDPI is justified by the health needs as well as current and burgeoning research capabilities of the Nation. An increase above BRDPI would allow new innovative ideas to be funded and would infuse existing programs to evolve as their research findings push them to higher levels of basic understanding, translation and clinical functionality.

AIRI also hopes that the subcommittee will support programs and policies that foster a sustainable, biomedical research workforce. The biomedical research community is dependent upon a knowledgeable and skilled workforce to address current and future critical health research challenges. The cultivation and preservation of this workforce is dependent upon several factors, including the ability to: recruit scientists and students globally; train researchers both in basic and clinical biomedical research; focus on career development initiatives to recruit and retain researchers at critical stages; support new and young investigators; and maintain the NIH extramural investigator salary cap at Executive Level I. By again maintaining the NIH extramural investigator salary cap (the salary level that extramural researchers may apply toward their NIH grants) at Executive Level I in the fiscal year 2007 Appropriations bill, Congress will ensure that extramural investigators' salaries are competitive with the salary level for intramural researchers at NIH. As we work to enhance biomedical research capabilities, we should not impose barriers that would discourage talented people from committing to careers in research.

In addition, AIRI urges Congress to support NIH-funded equipment and infrastructure programs. As the investment in medical research and the national biomedical research agenda have expanded, the need for acquisition and modernization of laboratory equipment and infrastructure has become critical. NIH equipment grants meet the specific infrastructure needs of research institutions to maximize productivity of their research grants.

Medical research is a long-term process and, in order to meet the challenges of improving human health, we must not diminish our Federal commitment and investment. It is essential to sustain the momentum of NIH-funded research so that it continues to meet the goal of improving the health of all Americans. AIRI would like to thank the subcommittee for its important work to ensure the health of the Nation, and we appreciate this opportunity to present recommendations concerning the fiscal year 2007 Appropriations bill.

PREPARED STATEMENT OF THE ASSOCIATION OF WOMEN'S HEALTH, OBSTETRIC AND NEONATAL NURSES (AWHONN)

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) appreciates the opportunity to provide comment on the fiscal year 2007 appropriations for nursing education, research, and workforce development programs as well as programs designed to improve maternal and child health. AWHONN is a membership organization of 22,000 nurses, and it is our mission to promote the health and well-being of all women and newborns. AWHONN members are registered nurses, nurse practitioners, certified nurse-midwives, and clinical nurse specialists who work in hospitals, physicians' offices, universities, and community clinics throughout the United States.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

AWHONN recommends a minimum of $7.5 billion in funding for HRSA

AWHONN is deeply concerned by the President's budget request of a $255 million cut in fiscal year 2007 to HRSA. Through its many programs and new initiatives, HRSA helps countless individuals live healthier, more productive lives. In this day

and age, rapid advances in research and technology promise unparalleled change in the Nation's health care delivery system. HRSA could be well positioned to meet these new challenges as it continues to provide for the Nation's most vulnerable citizens. In order to respond to these challenges, AWHONN asserts that HRSA will require an overall funding level of at least $7.5 billion for fiscal year 2007.

TITLE VIII—NURSING WORKFORCE DEVELOPMENT PROGRAMS UNDER HRSA

AWHONN recommends a minimum of $175 million in funding for Title VIII

Nursing workforce development programs are authorized under Title VIII of the Public Health Service Act. These programs are essential components of the American health care safety net, which brings critical services to our entire Nation. In addition, Title VIII programs are the only comprehensive Federal programs that provide annual funds for nursing education that help nursing schools and nursing students prepare to meet patient needs in a changing healthcare delivery system. These programs are also in institutions that train nurses for practice in medically underserved communities and Health Professional Shortage Areas. While the President's budget recommends level funding of Title VIII at $150 million for fiscal year 2007, AWHONN supports a minimum of $175 million in funding for Title VIII Nursing Workforce Development programs.

In 2002, Congress enacted the Nurse Reinvestment Act that provides funding for new and expanded programs such as scholarship and repayment programs like the Nurse Education Loan Repayment Program (NELRP), career ladders, internships and residencies, retention programs, and faculty loans designed to encourage students to consider nursing, keep nurses in the field, and ensure that nurse educators are plentiful enough to educate future nurses that we desperately need. These new programs received an initial appropriation of $20 million in fiscal year 2003, which was in addition to $93 million in funding provided for existing Title VIII programming. Unfortunately, due to limited funding in the first 2 years of the new authorization, the loan and scholarship programs have not been as successful as they could be in providing support to students in nursing schools. For example, NELRP is a competitive program that repays 60 percent of the qualifying loan balance of registered nurses selected for funding in exchange for 2 years of service at a critical shortage facility. In fiscal year 2005, HRSA made a total of 599 awards of this nature with an obligation of $19 million. These loans are imperative for continuing to bring nurses into underserved communities in addition to bringing nurses through their education and training years.

Nurses are essential health care providers, and the nursing community seeks the support of this subcommittee for bolstering existing nursing programs and creating new ones for recruiting students into the nursing profession. In addition, AWHONN seeks development of qualified faculty members for educating new nurses, and we need to create career opportunities for retaining nurses as faculty. The entire nursing workforce needs strengthening. As a result, it will take long-term planning and innovative initiatives at the local, State, and Federal level to assure an adequate supply of a qualified nurse workforce for the Nation. Federal investment in nursing education and retention programs is critical for meeting the health care needs of our Nation.

Increased funding for Title VIII will make a positive impact on the nursing shortage

Recent data from the Bureau of Health Professions, Division of Nursing's National Sample Survey of Registered Nurses—February 2002, confirm that of the approximately 2.9 million registered nurses in the Nation only 82 percent of these nurses work full-time or part-time in nursing. A dominant factor in this shortage is the impending retirement of up to 40 percent of the workforce by 2010. This surge in retirement will occur at the same time as the surging baby boomer population retires, which will noticeably cause an increase in demand for health care services and the services of registered nurses. In addition, the U.S. Bureau of Labor and Statistics detailed in February 2004 that registered nurses will have the largest projected 10-year job growth in the United States, with about 1 million new job openings by 2010.

The shortage of registered nurses and the effect of this shortage on staffing levels, patient safety and quality care demands attention and a significant increase in funding to bolster and improve these programs. Nursing is the largest health profession, yet only one-fifth of one percent of Federal health funding is directed to nursing education. A significant increase in funding for these programs can help lay the groundwork for expanding the nursing workforce, through education and clinical training and retention programs.

Increased funding for Title VIII will help fill the nursing gap

The nursing shortage is not confined solely to care providers, and this demand for providers is hindered by the growing shortage of nursing faculties. Nursing faculty continues to decrease in number. According to a 2005 survey on faculty vacancies from the American Association College of Nursing, the number of full-time nursing faculty required to "fill the nursing gap" is approximately 40,000. Currently, there are less than 20,000 full-time nursing faculty in the system. In 2004, nursing schools turned away more than 32,000 qualified applicants to entry-level baccalaureate and graduate nursing programs due to insufficient faculty, clinical sites, classroom space, clinical preceptors, and budget constraints, including almost 3,000 students who could potentially fill faculty roles. When all nursing programs are considered, the number turned away during the 2003–2004 academic year grows to more than 125,000 qualified applicants. Without sufficient support for current nursing faculty and adequate incentives to encourage more nurses to become faculty, nursing schools will fail to have the teaching infrastructure necessary to educate and train our next generation of nurses that we so desperately need.

While the capacity to implement faculty development is currently available through Section 811 and Section 831, adequate funding and direction is needed to ensure that these programs are fully operational. Options to provide support for full-time doctoral study are essential to rapidly prepare the nurse educators of the future. AWHONN recommends that a portion of the funds be allocated for faculty development and mentoring.

Increase funding for Title VIII will encourage advance practice nursing.

AWHONN recognizes the importance of the investment in advanced practice nursing programs. As in other professions, the advanced degree has become a necessary achievement for career advancement, and registered nurses who pursue the MSN degree are part of the cadre of nurses who go on to become faculty. Our Nation needs more nurses with basic training to enter the field, but focusing only on these nurses addresses only half the problem. The nursing shortage encompasses nursing faculty; both advanced practice nursing and basic nursing must receive additional funding but not one at the expense of the other.

TITLE V—MATERNAL AND CHILD HEALTH BUREAU (MCHB) UNDER HRSA

AWHONN recommends $850 million in funding for MCHB

The Maternal and Child Health Bureau incorporates valuable programs like the Traumatic Brain Injury program, Universal Newborn Hearing Screening, Emergency Medical Services for Children and Healthy Start, which were zeroed out, and the Maternal and Child Health Block Grant (MCH) that was level funded. These programs provide comprehensive, preventive care for mothers and young children, as well as an array of coordinated services for children with special needs. In fact, MCH serves over 80 percent of all infants in the United States, half of all pregnant women, and 20 percent of all children.

Restore Funding to the Universal Newborn Hearing Screening

The Children's Health Act of 2000 authorized funding for grants and programs to improve State-based newborn screening. Newborn screening is a public health activity used for early identification of infants affected by certain genetic, metabolic, hormonal or functional conditions for which there are effective treatment or intervention. Screening detects disorders in newborns that, left untreated, can cause death, disability, mental retardation and other serious illnesses.

Screening programs coordinated through MCHB help to ensure that every baby born in the United States receives, at a minimum, a universal core group of screening tests regardless of the State in which he or she is born. However, the administration again proposes eliminating universal newborn screening programs. It goes without saying that more disorders will go unnoticed if the affected newborns are not screened. AWHONN encourages the subcommittee to restore funding to the fiscal year 2006 level plus inflation for the newborn hearing screening program.

NATIONAL INSTITUTES OF HEALTH (NIH)

AWHONN recommends $29.75 billion in funding for the NIH

Multiple institutes housed under the National Institutes of Health (NIH) serve valuable roles in helping promote the importance of nursing in the health care industry along with the health and well-being of women and newborns. While AWHONN applauds the doubling of NIH's budget over the years, the President's Budget signals a level funding of NIH programs for fiscal year 2007. By allowing level funding, America will most certainly loose its edge in biomedical research.

NATIONAL INSTITUTE OF NURSING RESEARCH (NINR) UNDER NIH

AWHONN recommends $160 million in funding for NINR

The National Institute of Nursing Research (NINR) engages in significant research affecting areas such as health disparities among ethnic groups, training opportunities for management of patient care and recovery, and telehealth interventions in rural/underserved populations. This research allows nurses to continually refine their practice and provide quality patient care.

For example, NINR research is invaluable in contributing to improved health outcomes for women. Recent public awareness campaigns target differences in the manifestation of cardiovascular disease between men and women. The differing symptoms are the source of many missed diagnostic opportunities among women suffering from the disease, which is the primary killer of American women. Because of the emphasis on biomedical research in this country, there are few sources of funds for high-quality behavioral research for nursing other than NINR. It is critical that we increase funding in this area in an effort to optimize patient outcomes and decrease the need for extended hospitalization. While the President's budget recommended level funding for NINR at $137 million, AWHONN requests $160 million for fiscal year 2007.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT (NICHD) UNDER NIH

AWHONN recommends $1.328 billion in funding for NICHD

The National Institute of Child Health and Human Development (NICHD) seeks to ensure that every baby is born healthy, that women suffer no adverse consequences from pregnancy, and that all children have the opportunity for a healthy and productive life unhampered by disease or disability. For example, with increased funding, NICHD could expand its use of the NICHD Maternal-Fetal Medicine Network to study ways to reduce the incidence of low birth weight. Prematurity/low birth weight is the second leading cause of infant mortality in the United States and the leading cause of death among African American infants. AWHONN, like many organizations directly involved in programs to improve the health of women and newborns, looks to NICHD to provide national initiatives, such as the Maternal-Fetal Medicine Network that assists with the care of pregnant women and babies.

NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES (NIEHS) UNDER NIH

AWHONN recommends $680 million for NIEHS

Research conducted by the National Institute of Environmental Health Sciences (NIEHS) plays a critical role in what we know about the relationship between environmental exposures and the onset of diseases. Through the research sponsored by this Institute, we know that Parkinson's disease, breast cancer, birth defects, miscarriage, delayed or diminished cognitive function, infertility, asthma and many other diseases and ailments have confirmed environmental triggers. Our expanded knowledge, as a result, allows both policymakers and the general public to make important decisions about how to reduce toxin exposure and reduce the risk of disease and other negative health outcomes.

INDIAN HEALTH SERVICE (IHS) UNDER THE DEPARTMENT OF HEALTH AND HUMANS SERVICES (HHS)

AWHONN recommends $5.54 billion in funding for IHS

The Indian Health Service (IHS) is the principal Federal health care provider and health advocate for the American Indian and Alaska Native populations. The President's budget recognizes this importance by requesting an increase to the IHS budget of $124 million over the fiscal year 2006 level, bringing the total to $4 billion for fiscal year 2007. While AWHONN applauds this increase, we recommend further increased funding for IHS to fully achieve its goals.

A recent study of Federal health care spending per capita found that the United States spends $3,803 per year per Federal prisoner, while spending about half that amount for a Native American: $1,914. Per capita health care spending for the U.S. general population is $5,065 per year. A significant increase in funding over fiscal year 2006 spending levels is necessary for the Federal government to fulfill its responsibility to Indian Country and achieve its stated goals.

While the nursing shortage continues nationwide, IHS has been disproportionately affected by the lack of RNs. IHS nurses are older, with an average age of 48, and nearly 80 percent of RNs are over the age of 40. Further, the average vacancy rate for RNs is 14 percent. IHS administers three interrelated scholarship programs

designed to meet the health professional staffing needs of IHS and other health programs serving Indian people. These programs are severely under-funded. Targeted resources need to be invested in the IHS health professions programs in order to recruit and retain registered nurses in Indian Country.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) UNDER HHS

AWHONN recommends $8.65 billion in funding for CDC

The President's budget request funds the CDC at $8.2 billion for fiscal year 2007, a $179 million decrease over fiscal year 2006. It is critically important to increase funding for CDC. For example, CDC has been deeply involved in the prevention of birth defects through programs like the Folic Acid Education Campaign and the National Center on Birth Defects and Developmental Disabilities (NCBDDD) for over 30 years. The public health impact of birth defects is tremendous. Of the four million babies born each year in the United States, approximately 120,000 are born with a serious birth defect. CDC funds several programs critical to reducing the number of children born with birth defects, including funding to States for birth defects tracking systems. Due to lack of funds, in fiscal year 2005 CDC was only able to fund 15 States, which were down from 28 States in fiscal year 2004. Additional funding for these grants is needed to fund all of the States seeking CDC assistance for these critical surveillance programs.

Overall, AWHONN urges the Subcommittee to at a minimum restore all cuts to programs from fiscal year 2006 and adjust for inflation. Funding the aforementioned agencies and their programs at this minimum level will at least allow them to effectively operate and achieve their stated mission. AWHONN thanks you for your time, and we greatly appreciate this opportunity submit testimony on these critical areas of funding.

PREPARED STATEMENT OF THE CHARLES R. DREW UNIVERSITY OF MEDICINE AND SCIENCE

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2007

—Provide a 5 percent increase for fiscal year 2007 to the National Institutes of Health (NIH) and a proportional increase of 5 percent to the individual institutes and centers, specifically, the National Cancer Institute (NCI), the National Center for Research Resources (NCRR), and the National Center on Minority Health and Health Disparities (NCMHD).

—Continue to urge NCI to support the establishment of a collaborative minority health comprehensive research center at a historically minority institution in collaboration with the existing NCI Cancer Centers. Continue to urge NCRR and NCMHD to collaborate on the establishment of a minority health comprehensive research center.

—Urge the Department of Health and Human Service, particularly the Office of Minority Health (OMH), to support a Health Professions Leadership Development and Support Program at Charles R. Drew University of Medicine and Science.

Mr. Chairman and members of the subcommittee, thank you for the opportunity to present you with testimony. Charles R. Drew University of Medicine and Science is one of four predominantly minority medical schools in the country, and the only one located west of the Mississippi River. It is also one of the Hispanic serving institutions in California.

Charles R. Drew University of Medicine and Science is located in the Watts-section of South Central Los Angeles, and has a mission of rendering quality medical education to underrepresented minority students, and, through its affiliation with the University of California Los Angeles (UCLA) at the co-located King-Drew Medical Center, Drew provides valuable health care services to the medically underserved community. Through innovative basic science, clinical, and health services research programs, Charles R. Drew University works to address the health and social issues that strike hardest and deepest among inner city and minority populations.

The population of this medically underserved community is predominately African American and Hispanic. Many of these people would be without health care if not for the services provided by Charles R. Drew University of Medicine and Science. This record of service has led Charles R. Drew University (in partnership with UCLA School of Medicine) to be designated as a Health Resources and Services Administration Minority Center of Excellence.

RESEARCH: A RESPONSE TO HEALTH DISPARITIES

Racial and ethnic disparities in health outcomes for a multitude of major diseases in minority and underserved communities continue to plague this Nation that was built on a premise of equality. As articulated in the Institute of Medicine report entitled "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care", this problem is not getting better on its own. For example, African American males develop cancer 15 percent more frequently than white males. Similarly, African American women are not as likely as white women to develop breast cancer, but are much more likely to die from the disease once it is detected. In fact, according to the American Cancer Society, those who are poor, lack health insurance, or otherwise have inadequate access to high-quality cancer care, typically experience high cancer incidence and mortality rates. Despite these devastating statistics, we still do not have the resources to try to combat cancer in our communities.

In response to these findings and the high cancer rate in our own community, Charles R. Drew University of Medicine and Science has been working to build a Life Sciences Research Facility on its campus. The Center would specialize in providing not only medical treatment services for the community, but would also serve as a research facility, focusing on prevention and the development of new strategies in the fight against cancer. These strategies will be disseminated locally and nationally to communities at risk, as well as to others engaged in comprehensive cancer prevention programs.

The Life Sciences Research Building will provide the additional laboratory and support space necessary for further progress and development of innovative research in the clinical, biological, and life sciences. The new, three story building will provide Drew with state-of-the-art, flexible, modern biomedical and bio-behavioral research space. The proposed structure will provide 40,000 gross square feet, which is a significant increase over existing facilities at the University. Current research activities will be enhanced by additional laboratory and support space. The facility will house the Life Sciences Institute, building upon Drew's demonstrated strengths in clinical research, health services research, and basic science research. The Life Sciences Research Building will allow researchers in the College of Medicine and in the College of Allied Health to capitalize on the explosion of knowledge in genetics and biology, epidemiology, and health care delivery while exploring the interface between health, social, and economic infrastructure, cultural attitudes, and legislative policy. The Institute will play a unifying role for the life sciences across the University by bringing researchers from a wide array of disciplines together under one roof to collaborate in forward-looking research aimed at improving the health and quality of life of medically underserved and low-income communities.

Mr. Chairman, the support that this subcommittee has given to the National Institutes of Health (NIH) and its various institutes and centers has and continues to be invaluable to our university and our community. The dream of a state-of-the-art facility to aid in the fight against cancer and other diseases in our underserved community would be impossible without the resources of NIH.

To help facilitate the establishment of the Life Sciences Research Building at Charles R. Drew University of Medicine and Science, the University is seeking support from the National Institutes of Health's National Center for Research Resources (NCRR), the National Center for Minority Health and Health Disparities (NCMHD), and the National Cancer Institute (NCI).

HEALTH PROFESSIONS LEADERSHIP DEVELOPMENT AND SUPPORT PROGRAM

A Health Professions Leadership Development & Support Program is designed to: (1) enhance faculty recruitment and retention support for academicians providing for the supervision, instruction, and guidance of resident physicians-in-training in underserved communities; and (2) provide financial stability for the Office of Graduate Medical Education (GME) to ensure the sustainability of this national priority area.

This is a critical program for improving the minority pipeline as outlined in the recent report by a committee chaired by former Secretary of DHHS, Dr. Louis Sullivan titled "Missing Persons: Minorities in the Health Professions September 20, 2004". This report highlights the critical role played by institutions such as Drew University as a major training site for minority health care professionals and biomedical scientists. Specifically, this program will help to support the Drew University Graduate Medical Education program.

The Program will be used by the University to augment and/or recruit physician leaders in Family Medicine, Pediatrics, Psychiatry, Surgery, Internal Medicine, and Obstetrics/Gynecology in response to the need to develop external, non-County residency rotations. The Surgery residency program was not renewed as of 2005, how-

ever, the University plans to reapply for a new program as part of its faculty recruitment plans. These actions coincide with the affiliated medical center's anticipated efforts to secure institutional approval from the Centers for Medicare and Medicaid Services (CMS) as well as the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

CONCLUSION

Despite our knowledge about racial/ethnic, socio-cultural and gender-based disparities in health outcomes, the "gap" continues to widen in most instances. Not only are minority and underserved communities burdened by higher disease rates, they are less likely to have access to quality care upon diagnosis. As you are aware, in many minority and underserved communities preventive care and/or research is completely inaccessible either due to distance or lack of facilities and expertise. This is a critical loss of untapped potential in both physical and intellectual contributions to the entire society.

Even though institutions like Charles R. Drew are ideally situated (by location, population, and institutional commitment) for the study of conditions in which health disparities have been well documented, research is limited by the paucity of appropriate research facilities. With your help, the Life Sciences Research Facility will facilitate translation of insights gained through research into greater understanding of disparities.

We look forward to working with you to lessen the burden of health disparities and working with the Department of Health and Human Services to address the residency training program issues at Charles R. Drew University.

Mr. Chairman, thank you for the opportunity to present testimony on behalf of Charles R. Drew University of Medicine and Science.

PREPARED STATEMENT OF THE COOLEY'S ANEMIA FOUNDATION

SUBJECT

Mr. Somma's testimony thanks the subcommittee for the past support it has shown to the Cooley's Anemia Foundation and to the patients who are afflicted with this fatal genetic blood disease, also known as thalassemia. He urges the Committee to restore the funding cut in the President's budget from the Thalassemia Blood Safety Surveillance program at CDC. He discusses the importance of funding NIH research into this disease, particularly through NHLBI and NIDDK. He challenges the subcommittee to challenge the NIH to find the cure for thalassemia and, with it, for other similar diseases through a strong commitment to gene therapy. He urges continued support for the Thalassemia Clinical Research Network.

Mr. Chairman and Members of the Subcommittee: Thank you for the opportunity to present this testimony to the subcommittee today. My name is Frank Somma. I live in Holmdel, New Jersey and I am honored to serve as the National President of the Cooley's Anemia Foundation. I speak to you in my capacity as a volunteer. As many members of this subcommittee know, Cooley's anemia, or thalassemia, is a fatal genetic blood disease.

I could bog you down in a detailed scientific explanation of what happens physiologically when the human body cannot produce red blood cells in adequate numbers and of adequate quality to sustain life. I am not going to do that. The important thing for members of this subcommittee to remember about Cooley's anemia is that it is an incurable and fatal genetic blood disease. Period.

I also understand that I can present you with five pages of single-spaced testimony. I am not going to do that either. Instead, I am respectfully going to address the following three issues in a clear and succinct manner.

—The first is the immediate need to restore $2.0 million to the CDC to fund the thalassemia blood safety surveillance network.

—The second issue is the equally critical need for this subcommittee to commit our government to the development of a focused gene therapy program that is designed to cure something.

—The third issue is the urgent need to restore funding to NIH to assure the continuation of desperately needed research at NIDDK and for the Thalassemia Clinical Research Network at NHLBI.

Blood Safety Surveillance

Mr. Chairman, when a baby is diagnosed with Cooley's anemia, or thalassemia major, the standard of treatment is to begin that child on blood transfusions. I want to be very clear here that the treatment is not to give the child a blood transfusion;

it is to begin a lifetime treatment regimen of such invasive and dangerous intervention. Our patients receive a blood transfusion every two weeks for the rest of their lives.

Because Cooley's anemia patients are transfused so regularly, they are the early warning system for problems in the blood supply. If there is an emerging infection or other problem with the blood supply, it is our patients that will get it first.

Please understand that nearly every patient over the age of 18 today who has thalassemia major also has HIV or hepatitis C as a result of their transfusions—or did have it while they were still alive.

Blood safety is a major national issue. Surgical and trauma patients often have no choice but to be transfused. And, it is done an emergency basis many times. Nothing is more important to the patient at the time of transfusion than that they can be confident that the blood being pumped into their veins is free from infectious agents.

Utilizing the status of our patient population, the CDC has been monitoring the overall safety of the blood supply to this Nation and is prepared to issue an alert if a new virus or threat emerges. The blood safety surveillance program is currently operating very effectively through the Office of Hereditary Blood Diseases in the National Center for Birth Defects and Developmental Disability (NCBDDD) with about $2.0 million in funding. Inexplicably, the President's budget eliminates the program, leaving the blood supply vulnerable to contamination by new viruses or mutated versions of old viruses, putting all Americans not just those with Cooley's Anemia at risk.

We are respectfully requesting that the subcommittee restore this funding to the $2.0 million level that currently exists in order to continue to protect Americans from unnecessary infections and diseases that may occur in the blood supply.

Gene Therapy

Mr. Chairman, it has been a long time coming, but we are here to bring you some very good news about gene therapy. After a lot of false starts, we can now see a pathway for scientists to follow to help turn the promise of gene therapy into cures for single gene disorders. The problem to this point has not been one of science; it has been one of expectations. As a society, we forgot that science requires trial and error and that experiments are just that—experiments.

Today, gene therapy is advancing at a rapid pace in the rest of the world. Exciting work is being undertaken in Japan and China, in the UK and in France. Unfortunately, it is showing less progress the United States of America . . . and that is not right. We are the international leaders in scientific research and, in a field like this—fraught with financial, scientific and ethical minefields—it is essential that America be the world leaders. We set the highest ethical and moral standards on every one of these issues. We protect human subjects best. It is simply too important to leave it to anyone else.

For persons with a single cell mutation disorder like thalassemia or sickle cell disease or severe combined immune deficiency (SCID), gene therapy holds out great promise for a cure. In fact, the CAF has recently launched the CURE Campaign: Citizens United for Research Excellence. The theme of the campaign is "It is Time to Cure Something." We are now learning so much about how to deliver healthy genes to unhealthy cells that we cannot turn back—nor can we as a Nation afford to let our friends in Europe and Asia race ahead of us in the areas of biomedical research and gene therapy.

We hope that this Congress—speaking through this subcommittee—will do what we have done and dare the NIH and its grantees to "cure something." You are investing nearly $29 billion of taxpayer money in this agency that houses the "best and the brightest" and that funds "the best and the brightest." We as Americans must never stop striving to reach previously unimaginable heights. If that means that we have to shake up the status quo and create a new funding mechanism, let's do it. But let's not continue to follow the slow going incremental" path of the past.

We need to spend our tax dollars in a coordinated and focused manner that will maximize the chances that we will unlock the secrets of how to correct single gene defects. We are very close now, with an experiment currently being conducted—in France—that may be a breakthrough. It is time for the United States to step up and lead the world in this life-saving area of research.

NIH and the Thalassemia Clinical Research Network

Mr. Chairman, about 5 years ago, working closely with members of this subcommittee, the CAF convinced the NHLBI of the need to create a clinical research network that would allow the top researchers in the field to collaborate on desperately needed research projects using common protocols. Today, that network is

up and running and is the focal point for thalassemia research, most of which takes place in academic medical centers throughout the country.

However, there is a cloud hanging over this, and all other, research at NIH. As the Biomedical Research and Development Price Index continues to escalate, the buying power of a flat-funded NIH continues to decrease. There would be nothing wrong with this if we had cured thalassemia, and hemophilia, and cystic fibrosis, and all other genetic and non-genetic diseases. But that is not the case.

There is an enormous amount of work to be done. And there is no one else to do it but our National Institutes of Health, with the support of our Congress and President.

I urge the subcommittee to settle for nothing less than a 5 percent increase in funding for NIH so that the critical life saving research that is occurring there can continue. Some of our fellow citizens don't have another year to wait.

CONCLUSION

As I indicated at the outset, Mr. Chairman, I am not interested in filling the air with words. Unfortunately, I don't have the luxury of time to do that. The Cooley's Anemia Foundation has three priorities this year:

—Funding the blood safety surveillance program at CDC at $2.0 million;

—An enhanced focus on gene therapy designed to cure something; and,

—A five percent increase in NIH funding to continue current vital research programs.

Mr. Chairman, every night when I watch my beautiful, smart, talented 21 year old daughter Alicia put a needle under her skin to infuse a drug for 8–10 hours to remove the excess iron in her system from her bi-weekly blood transfusions, I know we can do better.

Please excuse my passion, but this is the United States of America. I know we can prevent this disease from happening in newborns. I know we can improve the lives of those who currently have it. And, most importantly, I am absolutely certain we can cure it once and for all.

You don't need five pages of testimony from me to do that. You just need to demand the very best from the very best—our scientists, our government, the patient advocacy community and ourselves.

Thank you for your very kind attention and for all the support this committee has shown to our patients and their families over the years.

PREPARED STATEMENT OF THE CROHN'S AND COLITIS FOUNDATION OF AMERICA

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS

(1) A 5 percent increase for the National Institute of Diabetes, and Digestive and Kidney Diseases, and the National Institute of Allergy and Infectious Diseases.

(2) $700,000 for the National Inflammatory Bowel Disease Epidemiological Program at the Centers for Disease Control and Prevention.

Mr. Chairman, thank you for the opportunity to submit testimony on behalf of the Crohn's and Colitis Foundation of America (CCFA). We greatly appreciate your leadership and the opportunity to work with you to improve the quality of life for our patients and families.

My name is Kenneth Edmonds and I serve on the National Board of Trustees for the CCFA, the Nation's oldest and largest voluntary organization dedicated to finding a cure for and to seeking to prevent Crohn's disease and ulcerative colitis.

Through research, education and support, CCFA is committed to improving the quality of life of children and adults affected by these diseases, collectively known as inflammatory bowel disease (IBD). I am one of them.

IBD is a chronic disorder that causes inflammation of the digestive tract. It affects approximately 1.4 million Americans, 30 percent of whom are diagnosed in their childhood. IBD can cause persistent diarrhea, severe abdominal pain, fever, and, at times, rectal bleeding. If complications develop, it also can lead to, among other conditions, anemia, liver disease and colorectal cancer.

Indeed, inflammatory bowel disease can be painful and debilitating. And, its impact is perhaps most devastating for children and adolescents, whose diagnoses often make them stand out at a time when they most want to fit in. Their disease can make them not only feel different, but look different as some adolescents with IBD may have delays in physical growth and puberty, causing them to appear younger and smaller than their peers. But, at any age, being diagnosed with IBD can bring change and challenge.

The news of my diagnosis came not in one, sudden rush, but rather in a long, gradual backslide—and into a hospital bed. In retrospect, I exhibited typical signs of IBD as early as 1993 while a student in college. But, unfortunately, I responded to those signals like too many adolescents and young adults—I overlooked them.

At the time, I experienced acute abdominal pain so sharp and sudden that I would double over. These cramps often came without warning, creating an intense urge to use the nearest bathroom. On these occasions and others, my stools had traces of blood.

But, because I was young and active, I didn't think that much about it. And, I certainly didn't talk about it, to anyone. I chalked these brief episodes up to my regimen, rather than my abdomen. I figured that I just needed to add more greens to my diet and add more hours to my sleep.

But, by 1996, after moving to Chicago, my symptoms had become too persistent, too serious and too severe to ignore. By the summer of that year, I had developed sores or ulcers on my tongue, making it difficult and painful to eat. I lost appetite and lost weight.

In addition to the persistent diarrhea and acute cramps, I also had developed a tear (a fissure) in the lining of my anus, which caused excruciating pain and bleeding during bowel movements. I also suffered from severe exhaustion.

As you can imagine, this was an agonizing predicament: I was losing weight, but could not eat. I was fatigued, but could not sleep. I had frequent, sudden bowel movements, but they caused sharp, piercing pain. Indeed, I had deteriorated dramatically; my condition relegating me to somewhere between bedridden and bathroom-bound.

A misdiagnosis, three, long, withering weeks, and a plane ride later, I found myself in the Washington Hospital Center under the care of my uncle, a gastroenterologist here in the District. After a series of tests, x-rays and examinations, I was diagnosed with Crohn's colitis and prescribed medications for my symptoms. Since my hospitalization 10 years ago, I am pleased to report that the disease has been in remission and I have enjoyed relatively good health.

But, Mr. Chairman, IBD is a life-long disease. While there are drug therapies to treat symptoms, there is no medical cure. And, its cause is unknown.

That's why CCFA's work has been so critical and groundbreaking.

RECOMMENDATIONS FOR FISCAL YEAR 2007

(1) National Institutes of Health

In fact, CCFA has developed incredibly successful research partnerships with the NIH, forging longstanding collaborations with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), which sponsors the majority of IBD research, and the National Institute of Allergy and Infectious Diseases (NIAID). CCFA provides crucial "seed-funding" to researchers, helping investigators gather preliminary findings, which in turn enables them to pursue advanced IBD research projects through the NIH. This approach led to the identification of the first gene associated with Crohn's—a landmark breakthrough in understanding this disease.

Mr. Chairman, CCFA's scientific leaders, with significant involvement from NIDDK, have developed an ambitious research agenda, titled "Challenges in Inflammatory Bowel Disease" that outlines and seeks to address the many opportunities that currently exist. Fortunately, the field of IBD is widely viewed within the scientific community as one of tremendous potential. To help capitalize on these opportunities, CCFA recommends that the subcommittee provide a 5 percent increase in funding for NIDDK and NIAID in fiscal year 2007. Moreover, CCFA requests that the subcommittee encourage these two institutes to expand their IBD research portfolios at a similar rate.

(2) Centers for Disease Control and Prevention

IBD Epidemiology Program

Mr. Chairman, CCFA estimates that 1.4 million people in the United States suffer from IBD, but there could be many more. We do not have an exact number due to these diseases' complexity and the difficulty in identifying them.

We are extremely grateful for your leadership in providing funding over the past 2 years for an epidemiology program on IBD at the Centers for Disease Control and Prevention. This program is yielding valuable information about the prevalence of IBD in the United States and increasing our knowledge of the demographic characteristics of the IBD patient population. If we are able to generate an accurate analysis of the geographic makeup of the IBD patient population, it will provide us with invaluable clues about the potential causes of IBD.

Unfortunately Mr. Chairman, the President has eliminated funding for this important program in his fiscal year 2007 budget for the CDC. CCFA encourages the subcommittee to restore support for the IBD Epidemiology Program at last year's level of $700,000.

Once again Mr. Chairman, thank you for the opportunity to submit written testimony

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PREPARED STATEMENT OF THE DIGESTIVE DISEASE NATIONAL COALITION

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS

—Provide increased funding for the National Institutes of Health (NIH) at an increase of 5 percent over fiscal year 2006. Increase funding for the National Cancer Institute (NCI), the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) and the National Institute of Allergy and Infectious Diseases (NIAID) by 5 percent.

—Continue focus on digestive disease research and education at NIH, including the areas of Inflammatory Bowel Disease (IBD), Hepatitis and other liver diseases, Irritable Bowel Syndrome (IBS), Colorectal Cancer, Endoscopic Research, Pancreatic Cancer, Celiac Disease, and Hemochromatosis.

—$30 million for the Centers for Disease Control and Prevention's (CDC) Hepatitis Prevention and Control activities.

—$25 million for the Center for Disease Control and Prevention's (CDC) Colorectal Cancer Screening and Prevention Program.

Chairman Specter, thank you for the opportunity to again submit testimony to the subcommittee. Founded in 1978, the Digestive Disease National Coalition (DDNC) is a voluntary health organization comprised of 23 professional societies and patient organizations concerned with the many diseases of the digestive tract. The Coalition has as its goal a desire to improve the health and the quality of life of the millions of Americans suffering from both acute and chronic digestive diseases.

The DDNC promotes a strong Federal investment in digestive disease research, patient care, disease prevention, and public awareness. The DDNC is a broad coalition of groups representing disorders such as Inflammatory Bowel Disease (IBD), Hepatitis and other liver diseases, Irritable Bowel Syndrome (IBS), Pancreatic Cancer, Ulcers, Pediatric and Adult Gastroesophageal Reflux Disease, Colorectal Cancer, Celiac Disease, and Hemochromatosis.

Mr. Chairman, the social and economic impact of digestive disease is enormous and difficult to grasp. Digestive disorders afflict approximately 65 million Americans. This results in 50 million visits to physicians, over 10 million hospitalizations, collectively 230 million days of restricted activity. The total cost associated with digestive diseases has been conservatively estimated at $60 billion a year.

The DDNC would like to thank the subcommittee for its past support of digestive disease research and prevention programs at the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC). With respect to the coming fiscal year, the DDNC is recommending an increase of 5 percent to $30.1 billion for the National Institutes of Health (NIH) and all of its Institutes.

Specifically the DDNC recommends

—$5.35 billion for the National Cancer Institute (NCI).

—$2 billion for the National Institute of Diabetes and Digestive and Kidney Disease (NIDDK).

—$4.89 billion for the National Institute of Allergy and Infectious Diseases (NIAID).

We at the DDNC respectfully request that any increase for NIH does not come at the expense of other Public Health Service agencies.

With the competing and the challenging budgetary constraints the subcommittee currently operates under, the DDNC would like to highlight the research being accomplished by NIDDK which warrants the increase for NIH.

INFLAMMATORY BOWEL DISEASE

In the United States today about 1 million people suffer from Crohn's disease and ulcerative colitis, collectively known as Inflammatory Bowel Disease (IBD). These are serious diseases that affect the gastrointestinal tract causing bleeding, diarrhea, abdominal pain, and fever. Complications arising from IBD can include anemia, ulcers of the skin, eye disease, colon cancer, liver disease, arthritis, and osteoporosis. Crohn's disease and ulcerative colitis are not usually fatal but can be devastating.

The cause of IBD is still unknown, but research has led to great breakthroughs in therapy.

In recent years researchers have made significant progress in the fight against IBD. In 1998, the FDA approved the first drug ever specifically to fight Crohn's disease, a remarkable milestone. The DDNC encourages the subcommittee to continue its support of IBD research at NIDDK and NIAID at a level commensurate with the overall increase for each institute. The DDNC would like to applaud the NIDDK for its strong commitment to IBD research through the Inflammatory Bowel Disease Genetics Research Consortium. The DDNC urges the Consortium to continue its work in IBD research. Given the recent advancements in treatment for these diseases and the increased risk that IBD patients have for developing colorectal cancer, the DDNC strongly believes that generating improved epidemiological information on the IBD population is essential if we are to provide patients with the best possible care. Therefore the DDNC and its member organization the Crohn's and Colitis Foundation of America encourage the CDC to initiate a nationwide IBD surveillance and epidemiological program in fiscal year 2007.

HEPATITIS C: A LOOMING THREAT TO HEALTH

It is estimated that there are over 4 million Americans who have been infected with Hepatitis C of which over 2.7 million remain chronically infected. About 10,000 die each year and the Centers for Disease Control and Prevention (CDC) estimates that the death rate will more than triple by 2010 unless there is additional research, education, and more effective treatments and public health interventions. Hepatitis C infection is the largest single cause for liver transplantation and one of the principal causes of liver cancer and cirrhosis. There is currently no vaccine for hepatitis C, and treatment has limited success, making the infection among the most costly diseases in terms of health care costs, lost wages, and reduced productivity. Patients who are older at the time of infection, those who continually ingest alcohol, and those co-infected with HIV demonstrate accelerated progression to more advanced liver disease.

The DDNC applauds all the work NIH and CDC have accomplished over the past year in the areas of hepatitis and liver disease. The DDNC urges that funding be focused on expanding the capability of State health departments, particularly to enhance resources available to the hepatitis C State coordinators. The DDNC also urges that CDC increase the number of cooperative agreements with coalition partners to develop and distribute health education, communication, and training materials about prevention, diagnosis and medical management for hepatitis A, B, and C.

The DDNC supports $30 million for the CDC's Hepatitis Prevention and Control activities. The hepatitis division at CDC supports the hepatitis C prevention strategy and other cooperative nationwide activities aimed at prevention and awareness of hepatitis A, B, and C. The DDNC also urges the CDC's leadership and support for the National Viral Hepatitis Roundtable to establish a comprehensive approach among all stakeholders for viral hepatitis prevention, education, strategic coordination, and advocacy.

COLORECTAL CANCER PREVENTION

Colorectal cancer is the third most commonly diagnosed cancer for both men and woman in the United States and the second leading cause of cancer-related deaths. Colorectal cancer affects men and women equally. According to the American Cancer Society, this year alone about 135,400 individuals will be diagnosed with colorectal cancer, and of those diagnosed 56,700 patients will die. Although colorectal cancer is preventable and curable when polyps are detected early, a General Accounting Office report issued in March 2000 documented that less than 10 percent of Medicare beneficiaries have been screened for colorectal cancer. This report revealed a tremendous need to inform the public about the availability of screening and educate health care providers about colorectal cancer screening guidelines. In 2003, the New York City Department of Health has recommended colonoscopy for everyone over age 50 to prevent colorectal cancer.

The DDNC recommends a funding level of $25 million for the CDC's Colorectal Cancer Screening and Prevention Program. This important program supports enhanced colorectal screening and public awareness activities throughout the United States. The DDNC also supports the continued development of the CDC-supported National Colorectal Cancer Roundtable, which provides a forum among organizations concerned with colorectal cancer to develop and implement consistent prevention, screening, and awareness strategies.

PANCREATIC CANCER

In 2006, an estimated 33,730 people in the United States will be found to have pancreatic cancer and approximately 32,300 will die from the disease. Pancreatic cancer is the fifth leading cause of cancer death in men and women. Only 1 out of 4 patients will live 1 year after the cancer is found and only 1 out of 25 will survive 5 or more years. Although we do not know exactly what causes pancreatic cancer, several risk factors linked to the disease have been identified:

(1) Age: Most people are over 60 years old when the cancer is found;

(2) Sex: Men have pancreatic cancer more often than women;

(3) Race: African Americans are more likely to develop pancreatic cancer than are white or Asian Americans;

(4) Smoking;

(5) Diet: Increased red meats and fats; and

(6) Diabetes.

The National Cancer Institute (NCI) has established a Pancreatic Cancer Progress Review Group charged with developing a detailed research agenda for the disease. The DDNC encourages the subcommittee to provide an increase for pancreatic cancer research at a level commensurate with the overall percentage increase for NCI and NIDDK.

IRRITABLE BOWEL SYNDROME (IBS)

IBS is a disorder that affects an estimated 35 million Americans. The medical community has been slow in recognizing IBS as a legitimate disease and the burden of illness associated with it. Patients often see several doctors before they are given an accurate diagnosis. Once a diagnosis of IBS is made, medical treatment is limited because the medical community still does not understand the pathophysiology of the underlying conditions.

Living with IBS is a challenge, patients face a life of learning to manage a chronic illness that is accompanied by pain and unrelenting gastrointestinal symptoms. Trying to learn how to manage the symptoms is not easy. There is a loss of spontaneity when symptoms may intrude at any time. IBS is an unpredictable disease. A patient can wake up in the morning feeling fine and within a short time encounter abdominal cramping to the point of being doubled over in pain and unable to function.

The unpredictable bowel symptoms may make it next to impossible to leave your home. It is difficult to ease the pain that may repeatedly occur periodically throughout the day. A patient can become reluctant to eat for fear that just eating a meal will trigger symptoms all over again. IBS has a broad and significant impact on a person's quality of life. It strikes individuals from all walks of life and results in a significant toll of human suffering and disability.

While there is much we don' understand about the causes and treatment of IBS, we do know that IBS is a chronic complex of systems affecting as many as one in five adults. In addition:

(1) It is reported more by women than men;

(2) It is the most common gastrointestinal diagnosis among gastroenterology practices in the United States;

(3) It is a leading cause of worker absenteeism in the United States; and

(4) It costs the U.S. Health Care System an estimated $8 billion annually.

Mr. Chairman, much more can still be done to address the needs of the nearly 35 million Americans suffering from irritable bowel syndrome and other functional gastrointestinal disorders. The DDNC recommends that NIDDK increase its research portfolio on Functional Gastrointestinal Disorders and Motility Disorders.

GASTROPARESIS

Gastroparesis, or paralysis of the stomach, refers to a stomach that empties slowly. Gastroparesis is characterized by symptoms from the delayed emptying of food, namely: bloating, nausea, vomiting or feeling full after eating only a small amount of food. Gastroparesis can occur as a result of several conditions; it can occur in up to 30 percent to 50 percent of patients with diabetes mellitus. A person with diabetic gastroparesis may have episodes of high and low blood sugar levels due to the unpredictable emptying of food from the stomach, leading to diabetic complications. Other causes of gastroparesis include Parkinson's disease and some medications, especially narcotic pain medications. In many patients a cause of the gastroparesis cannot be found and the disorder is termed idiopathic gastroparesis. Over the last several years, as more is being found out about gastroparesis, it has become clear this condition affects many people and the condition can cause a wide range of symptoms of differing severity.

CELIAC DISEASE

Celiac Disease is a life-long condition in which the body develops an allergy to gluten, a protein found in wheat, barley, and rye, which can result in damage to the small intestine. Celiac disease affects as many as 2 million Americans. Onset of the disease can occur at any age. The common symptoms of Celiac Disease include fatigue, anemia, chronic diarrhea or constipation, weight loss, and bone pain. The only treatment for celiac disease is strict adherence to a gluten-free diet. Undiagnosed and untreated celiac disease can lead to other disorders such as osteoporosis, infertility, neurological conditions, and in rare cases cancer. Persons with Celiac Disease often have other associated autoimmune disorders as well.

DIGESTIVE DISEASE COMMISSION

In 1976, Congress enacted Public Law 94–562, which created a National Commission on Digestive Diseases. The Commission was charged with assessing the State of digestive diseases in the United States, identifying areas in which improvement in the management of digestive diseases can be accomplished and to create a long-range plan to recommend resources to effectively deal with such diseases. The Commission's subsequent report in 1979 laid the groundwork for significant progress in the area of digestive disease research. After almost 25 years, however, the burden of digestive diseases among the U.S. population remains substantial.

The DDNC recognizes the creation of the National Commission on Digestive Diseases, and looks forward to working with the National Commission to address the numerous digestive disorders that remain in today's diverse population.

CONCLUSION

The DDNC understands the challenging budgetary constraints and times we live in that this subcommittee is operating under, yet we hope you will carefully consider the tremendous benefits to be gained by supporting a strong research and education program at NIH and CDC. Millions of Americans are pinning their hopes for a better life, or even life itself, on digestive disease research conducted through the National Institutes of Health.

Mr. Chairman, on behalf of the millions of digestive disease sufferers, we appreciate your consideration of the views of the Digestive Disease National Coalition. We look forward to working with you and your staff.

DIGESTIVE DISEASE NATIONAL COALITION

The Digestive Disease National Coalition was founded 25 years ago. Since its inception, the goals of the coalition have remained the same: to work cooperatively to improve access to and the quality of digestive disease health care in order to promote the best possible medical outcome and quality of life for current and future patients with digestive diseases.

PREPARED STATEMENT OF THE DORIS DAY ANIMAL LEAGUE

The Doris Day Animal League represents 350,000 members and supporters nationwide who support a strong commitment by the Federal Government to research, development, standardization, validation and acceptance of non-animal and other alternative test methods. We are also submitting our testimony on behalf of the Humane Society of the United States and The Procter & Gamble Company. Thank you for the opportunity to present testimony relevant for the fiscal year 2007 budget request for the National Institute of Environmental Health Sciences (NIEHS) for the fiscal year 2007 activities of the National Toxicology Program Center for the Evaluation of Alternative Toxicological Test Methods (NICEATM), the support center for the Interagency Coordinating Committee for the Validation of Alternative Test Methods (ICCVAM).

In 2000, the passage of the ICCVAM Authorization Act into Public Law 106–545, created a new paradigm for the field of toxicology. It requires Federal regulatory agencies to ensure that new and revised animal and alternative test methods be scientifically validated prior to recommending or requiring use by industry. An internationally agreed upon definition of validation is supported by the 15 Federal regulatory and research agencies that compose the ICCVAM, including the EPA. The definition is: "the process by which the reliability and relevance of a procedure are established for a specific use."

FUNCTION OF THE ICCVAM

The ICCVAM performs an invaluable function for regulatory agencies, industry, public health and animal protection organizations by assessing the validation of new, revised and alternative toxicological test methods that have interagency application. After appropriate independent peer review of the test method, the ICCVAM recommends the test to the Federal regulatory agencies that regulate the particular endpoint the test measures. In turn, the Federal agencies maintain their authority to incorporate the validated test methods as appropriate for the agencies' regulatory mandates. This streamlined approach to assessment of validation of new, revised and alternative test methods has reduced the regulator burden of individual agencies, provided a "one-stop shop" for industry, animal protection, public health and environmental advocates for consideration of methods and set uniform criteria for what constitutes a validated test methods. In addition, from the perspective of animal protection advocates, ICCVAM can serve to appropriately assess test methods that can refine, reduce and replace the use of animals in toxicological testing. This function will provide credibility to the argument that scientifically validated alternative test methods, which refine, reduce or replace animals, should be expeditiously integrated into Federal toxicological regulations, requirements and recommendations.

HISTORY OF THE ICCVAM

The ICCVAM is currently composed of representatives from the relevant Federal regulatory and research agencies. It was created from an initial mandate in the NIH Revitalization Act of 1993 for NIEHS to "(a) establish criteria for the validation and regulatory acceptance of alternative testing methods, and (b) recommend a process through which scientifically validated alternative methods can be accepted for regulatory use." In 1994, NIEHS established the ad hoc ICCVAM to write a report that would recommend criteria and processes for validation and regulatory acceptance of toxicological testing methods that would be useful to Federal agencies and the scientific community. Through a series of public meetings, interested stakeholders and agency representatives from all 14 regulatory and research agencies, developed the NIH Publication No. 97–3981, "Validation and Regulatory Acceptance of Toxicological Test Methods." This report, and subsequent revisions, has become the sound science guide for consideration of new, revised and alternative test methods by the Federal agencies and interested stakeholders.

After publication of the report, the ad hoc ICCVAM moved to standing status under the NIEHS' NICEATM. Representatives from Federal regulatory and research agencies and their programs have continued to meet, with advice from the NICEATM's Advisory Committee and independent peer review committees, to assess the validation of new, revised and alternative toxicological methods. Since then, several methods have undergone rigorous assessment and are deemed scientifically valid and acceptable. In addition, the ICCVAM is working to streamline assessment of methods from the European Union (EU) that have already been validated for use within the EU. The open public comment process, input by interested stakeholders and the continued commitment by the Federal agencies has led to ICCVAM's success. It has resulted in a more coordinated review process for rigorous scientific assessment of the validation of new, revised and alternative test methods.

REQUEST FOR APPROPRIATIONS

On December 19, 2000, the "ICCVAM Authorization Act" which makes the entity a permanent standing committee, was signed into Public Law No. 106–545. For several years, the NIEHS has provided financial resources to the NICEATM for ICCVAM's activities. In order to ensure that Federal regulatory agencies and their stakeholders benefit from the work of the ICCVAM, it is important for NIEHS to provide funding at an appropriate level. We respectfully request a fiscal year funding level of $4 million.

REQUEST FOR COMMITTEE REPORT LANGUAGE

The NIEHS should support the NICEATM/ICCVAM in creating a five-year roadmap for assertively setting goals to prioritize ending the use of antiquated animal tests for specific endpoints. While the stream of methods forwarded to the ICCVAM for assessment has remained relatively steady, it is imperative that the ICCVAM take a more proactive role in isolating areas where new methods development is on the verge of replacing animal tests. These areas should form a collective call by the Federal agencies that compose ICCVAM to fund any necessary additional research, development, validation and validation assessment that is required to eliminate the

animal methods. We also strongly urge the NICEATM/ICCVAM to closely coordinate research, development and validation efforts with its European counterpart, the European Centre for the Validation of Alternative Methods (ECVAM) to ensure the best use of available funds and sound science. This coordination should also reflect a willingness by the Federal agencies comprising ICCVAM to more readily accept validated test methods proposed by the ECVAM to ensure industry has a uniform approach to worldwide chemical safety evaluation.

We also respectfully request the subcommittee consider the following report language for the Senate Labor, Health and Human Services, Education and Related Agencies Appropriations bill:

"The Committee commends the National Interagency Center for the Evaluation of Alternative Methods/Interagency Coordinating Committee on the Validation of Alternative Methods (NICEATM/ICCVAM) for its leadership role in the assessment of new, revised and alternative scientifically validated methods for the Federal government. The Committee also commends the National Toxicology Program (NTP) for finalizing its 'Roadmap to Achieve the NTP Vision, A Toxicology Program for the 21st Century', which commits to 'develop and validate improved testing methods and, where feasible, ensure that they reduce, refine or replace the use of animals' as one of its top four goals.

"The Committee directs the NICEATM/ICCVAM, in partnership with the relevant Federal agency program offices and the NTP, to build on the NTP Roadmap to create a 5-year plan to research, develop, translate and validate new and revised non-animal and other alternative assays for integration of relevant and reliable methods into the Federal agency testing programs. In this 5-year plan the Federal agency program offices shall be directed to identify areas of high priority for new and revised non-animal and alternative assays or batteries of those assays to create a path forward for the replacement, reduction and refinement of animal tests, when this is scientifically valid and appropriate. The Committee directs a transparent, public process for developing this plan and recommends the plan be presented to the Committee by November 15, 2007. Funding for developing the plan shall be from the NIEHS and the NTP, and shall not reduce the NICEATM/ICCVAM funding base."

PREPARED STATEMENT OF THE DYSTONIA MEDICAL RESEARCH FOUNDATION

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS

—Provide increased funding for the National Institute of Health at an increase of 5 percent over fiscal year 2006. Increase funding for the National Institute of Neurological Disorders and Stroke (NINDS), the National Institute of Deafness and other Communication Disorders (NIDCD), and the National Eye Institute (NEI) by 5 percent.
—Fiscal Year 2007 Recommendations for NIH
  —NIH: $30 billion
  —NINDS: $1.61 billion
  —NEI: $700.4 million
  —NIDCD: $412.7 million
—Continue to accelerate funding for intramural and extramural dystonia research at NINDS.
—Continue to expand NIDCD's intramural and extramural research on dysphonia.
—Continue to expand NEI's intramural and extramural research on dystonia.

Chairman Specter, thank you for the opportunity to submit testimony to the subcommittee on behalf of the Dystonia Medical Research Foundation (DMRF). Dystonia has affected the lives of many Americans and we are thankful to be able to provide for you our recommendations for fiscal year 2007 Federal funding with regards to dystonia research.

Dystonia is a neurological disorder characterized by powerful and painful involuntary muscle spasms that causes the body to twist, repetitive jerking movements, and sustained postural deformities. There are several different variations of dystonia, including: focal dystonias which affect specific parts of the body, such as the arms, legs, neck, jaw, eyes, vocal cords; and generalized dystonia, affecting many parts of the body at the same time. Some forms of dystonia are genetic and others are caused by injury or illness. Dystonia does not affect a person's consciousness or intellect, but is a chronic and progressive movement disorder for which, at this time, there is no known cure. The Foundation estimates that some form of dystonia affects about 300,000 people in North America.

Even though there is no known cure for dystonia, there are treatments to lessen the severity of the symptoms of the disease such as oral medications, botulinum toxin injections, and in some cases surgery. Having increased access to these medical therapies is becoming an increasing larger issue for the community as a whole.

In the past few decades, dystonia researchers have made several exciting scientific advancements and have been able to rapidly turn laboratory and clinical research into diagnostic examinations and treatment procedures, directly benefiting those affected. Genetics, in particular, is opening up a new understanding into the cause and pathophysiology of the disorder. Thus far, 13 dystonia related genes or gene loci have been identified. In 1997, the DYT1 gene for childhood early onset dystonia was identified, and we now have a genetic test available to confirm diagnosis of this particular type of dystonia. Most recently, in 2002, the gene for myoclonus dystonia was identified. However the community is still without a diagnostic test and misdiagnosis still occurs too frequently.

Deep brain stimulation is a surgical procedure that was originally developed to treat Parkinson's disease but is now being applied to severe cases of dystonia. Deep brain stimulation has drastically improved the lives of dozens of dystonia patients during the past few years. Individuals who were previously bedridden by muscle spasms and pain are able to walk without assistance, to speak clearly, to dress themselves, to get a driver's license, to date, to travel, and to live the life of an able-bodied person. Deep brain stimulation is currently used primarily to treat severe cases of generalized dystonia but its promising role in treating focal dystonias is being explored. Surgical interventions are a crucial and active area of dystonia research.

RESEARCH, AWARENESS, AND SUPPORT

Now is an exciting time to be involved in dystonia research and awareness. Researchers are becoming more interested in movement disorders and dystonia at the National Institutes of Health (NIH), and research is yielding promising clues for better understanding and management of this disorder.

One way the Dystonia Medical Research Foundation has advocated for more research on dystonia, is by funding "seed" grants to researchers. Thus far the Dystonia Foundation has funded over 415 grants and fellowships totaling more than $21 million. Due to our advocacy there are a growing number of talented researchers dedicated to understanding the biochemistry of dystonia, genetic causes, new therapeutics and the necessity of an epidemiology study.

Another primary goal of the Dystonia Foundation is education of both lay and medical audiences. The Foundation conducts regular medical workshops and patient symposiums to present, discuss, and disseminate comprehensive medical and research data on dystonia. In January 2001, NINDS co-sponsored a genetics and animal models meeting, designed to involve not only prominent researchers but inviting junior investigators to participate in the discussions. In September, 2005 NIH funded a workshop on "Rehabilitation in Dystonia" at which leading experts from neurosurgeons and neurologists to physical therapists, psychologists, and biomedial engineers argued for more aggressive research and the use of new concepts and tools in the treatment of dystonia and in 2006 NIH is funding a science workshop on the dystonia protein torsinA/Nuclear envelope. On June 6 & 7 a NINDS Research Agenda Workshop will take place.

The Young Investigators Award Program and the Residency Program are in place to entice emerging medical professionals into the field of dystonia research and cultivate future dystonia experts.

Since 1995, over 10,000 educational medical videos have been distributed to hospitals, medical and nursing schools, and at medical conventions. In addition to medical and coping publications, we have a children's video to educate families and increase public awareness of this devastating disorder in younger populations. Media awareness is conducted throughout the year, and especially during Dystonia Awareness Week, observed nationwide from June 4 through 11. Local volunteers have been successful in securing news stories on dystonia in local venues as well as national media shows such as Good Morning America, The Oprah Winfrey Show, and Maury Povich. Through his friendship with the mother of a dystonia patient, screen star Kirk Cameron has taken an interest in promoting dystonia awareness, and the Dystonia Foundation is in the process of investigating the possibility of a public service announcement and several appearances at fundraising events. In the Fall of 2006 the new dystonia documentary entitled TWISTED will be premiered on PBS.

The Dystonia Foundation has over 100 chapters, support groups, and area contacts across North America. In addition, there are chairpersons whose mission is to

promote awareness, children's advocacy, development, extension, Internet resources, leadership, medical education, and symposiums. Furthermore, patient symposiums are held internationally and regionally to provide the latest medical and coping information to dystonia patients and others interested in the disorder.

DYSTONIA AND THE NATIONAL INSTITUTES OF HEALTH

The Dystonia Medical Research Foundation recommends an increase to $31.6 billion or 5 percent for NIH overall, and a 5 percent increase for NINDS, and NIDCD. We at DMRF request that this increase for NIH does not come at the expense of other Public Health Service agencies.

We also urge the subcommittee to recommend that NINDS provide the necessary funding for additional extramural research. There is also an imperative need for NINDS to increase its efforts to educate the public and medical community about dystonia through co-sponsorship of workshops and seminars. We also encourage the subcommittee to support NIDCD in its efforts to revamp its strategic planning process by implementing a Strategic Planning Group which will help NIDCD as they: consider applications for high program priority; develop program announcements and requests for applications; and develop new research areas in the Intramural Research Program.

The National Institute of Neurological Disorders and Stroke (NINDS) awarded eleven grants for dystonia research in response to the Program Announcement, "Studies into the Causes and Mechanisms of Dystonia" (August 2002). These awards covered a wide range of research areas, which included gene discovery, the genetics and genomics of dystonia, the development of animal models of primary and secondary dystonia, molecular and cellular studies inherited forms of dystonia, epidemiology studies, and brain imaging. In addition, the National Institute on Deafness and Other Communication Disorders (NIDCD) funded an eighth study on brainstem systems and their role in spasmodic dysphonia.

DMRF also supports the many intramural researchers studying dystonia. Research includes: exploring improved clinical rating scales for dystonia, elevations of sensory motor training, utilizing Botox as a possible treatment for focal hand dystonia, characterization of abnormalities in sensory regions of the brain, treatments for spasmodic dysphonia, deep brain stimulation (the direct electrical stimulation of specific brain targets), non-invasive transcranial brain stimulation, anatomy imaging of the affect of dystonia on brain activity, and exploring the link between laryngitis and spasmodic dysphonia. The public awareness impact of pianist Leon Fleisher's treatment through the NIH intramural research program has had a tremendously positive impact.

NINDS continues to work with dystonia research and voluntary disease groups in the community. In June 2005, NINDS sponsored a workshop on spasmodic dysphonia, which was held at the NIH and was supported by the NINDS and the NIH Office of Rare Diseases. NIH staff are currently drafting a white paper on the results of the meeting and future research opportunities for improving the diagnosis, understanding the pathogenesis, developing new treatments, and preventing spasmodic dysphonia. Another NINDS laboratory is investigating several neurodegenerative disorders, including a form of hereditary dystonia known as the Mohr-Tranebjaerg deafness-dystonia syndrome. This form of dystonia is inherited through the X chromosome. The NINDS laboratory is investigating how abnormalities in a specific protein lead to the death of affected cells.

Dystonia is the third most common movement disorder after Parkinson's Disease and tremor, and effects many times more people than better known disorders such as Huntington's Disease, muscular dystrophy and ALS or Lou Gehrig's Disease. We ask that NINDS fund dystonia-specific extramural research at the same level that it supports research for other neurological movement disorders.

CONCLUSION

The ultimate goal of the Dystonia Foundation is a cure for dystonia. Until that goal is realized, we are hungry for knowledge about the nature of dystonia and for more effective treatments with fewer side effects. We have amassed many exceptional and diligent researchers; who are committed to our goal, and our top priority is funding their very important research. But the Foundation cannot do it alone. We need Federal support through NIH to continue to fund quality scientific research and eliminate this debilitating disease.

Combine the thwarting of scientific progress with the decreased access to therapies and all the progress of the last few years could be wiped away. We ask that you aggressively support medical research, specifically for movement disorders and

brain research. By doing so, you are doing a tremendous service for my family and myself and to the hundreds of thousands of people and families affected by dystonia.

Thank you very much.

PREPARED STATEMENT OF THE FSH SOCIETY

Chairman Specter, Senator Harkin and members of the subcommittee, I am Daniel Perez, President & CEO of the FSH Society. The FSH Society is a non-profit volunteer health agency organized by patients for patients with facioscapulohumeral muscular dystrophy (FSHD). Our purpose is to be a resource for individuals and families with FSH muscular dystrophy (FSHD), represent them and advocate on their behalf. On behalf of the FSH Society and its members, thank you for this opportunity to testify.

FSHD is the third most prevalent form of muscle disease and the second most prevalent adult muscular dystrophy. It affects 1/20,000 people. For men, women, and children the major consequence of inheriting FSHD is a lifelong progressive and severe loss of all skeletal muscles. The FSH Society was created because of a need for a comprehensive resource for FSHD individuals and families. A world leader in combating muscular dystrophy it has provided well over a million dollars in seed grants to pioneering researchers worldwide and created an international collaborative network of patients and researchers. The Society relies entirely on private grants, donations and philanthropy. Since our establishment in 1991, our major focus has been to help facilitate Federal research agencies such as the National Institutes of Health (NIH) grow funding and programs for FSHD research. The Society has submitted 28 written and five oral testimonies to Senate and House Appropriations Subcommittees on Labor, Health, Human Services and Education on the need for more NIH funding on FSHD.

The NIH often applauds the effort and dedication of the Society in expanding research efforts in FSHD and bringing additional attention to this dystrophy. We commend the Director of the NIH, Dr. Elias Zerhouni, for the significant efforts made by his agency in muscular dystrophy. Between 1987 and 2005, the overall NIH funding for dystrophy increased from $4.6 million to $39.3 million. Since 2000, the FSHD budget has increased from $400,000 to $2.1 million (fiscal year 2006 estimated). We applaud Dr. Stephen I. Katz, Director, National Institute of Arthritis and Musculoskeletal Disorders (NIAMS) and Chairman of the Muscular Dystrophy Coordinating Committee (MDCC), and John D. Porter, Program Director Muscular Dystrophy, National Institute of Neurological Disorders and Stroke (NINDS) and Executive Secretary MDCC, for their extraordinary comprehension, accuracy and for the speed in which the NIH Action Plan for Muscular Dystrophy was researched, compiled, written, and approved. The NIH is making significant investments to understand muscular dystrophy research needs and has made excellent choices in recruiting program staff with the ability to understand the extremely complex nature of muscular dystrophy. However, to this day, the NIH reports difficulty in growing and expanding its FSH muscular dystrophy research portfolio and in receiving sufficient numbers of investigator-submitted applications of high quality.

THE MD–CARE ACT, PUBLIC LAW 107–84

Congress enacted The Muscular Dystrophy Community Assistance, Research and Education Amendments of 2001 (the MD–CARE Act, Public Law 107–84) that was signed into law on December 18, 2001. Both the Senate and House acted with force and clarity to mandate the NIH and other applicable Federal agencies, to immediately expand and intensify research on all forms of muscular dystrophy. The MD–CARE Act declared that: (1) the Director of the NIH work with the Directors of NIAMS, NINDS and NIH National Institute of Child Health and Human Development (NICHD) to expand and intensify research on all nine types of dystrophy described in the Act; (2) Centers of excellence for research should be established for all nine types of dystrophy; (3) a MDCC with two-thirds government and one-third public members be established to coordinate activities across NIH and other national research agencies on all forms of dystrophy; and; (4) the MDCC to submit a research action plan for conducting, and supporting research and education for all nine types of dystrophy. The MD–CARE Act also requires annual updates on research funding amounts by the Department of Health and Human Services (DHHS) for Duchenne, Myotonic, FSHD and other muscular dystrophies.

In August 2004, the MDCC submitted an initial report for the NIH Muscular Dystrophy Research and Education Plan to Congress which was put through a more intensive planning process that involved external scientific experts in the field of mus-

cular dystrophy and muscle disease. This detailed version of the MDCC "Action Plan for the Muscular Dystrophies" was submitted to Congress in December 2005.

FSHD is prominently and well represented in the five sections of the NIH "Action Plan for the Muscular Dystrophies." Three key sections for FSHD research are: Mechanisms Section, Research Objective 3, "Define the molecular pathogenetic mechanisms that lead to facioscapulohumeral muscular dystrophy"; Mechanisms Section, Research Objective 4, "Establish mouse (and cellular) models for facioscapulohumeral muscular dystrophy, specific to emerging candidate genes and/or disease genomics, to understand the epigenetic mechanisms and for the development of novel intervention strategies"; and, the Infrastructure Section, Research Objective 13, "Stimulate international collaborations and infrastructure sharing to ensure that opportunities are exploited and resources are used to maximum advantage, particularly in cases of novel opportunity or for the rare and/or understudied muscular dystrophies." The full description and text of research objective three in the mechanisms section illustrates that the NIH fully comprehends what needs to be done to achieve progress in FSHD.[1]

It is absolutely clear that muscular dystrophy is a high priority for the NIH and it understands the research that needs be developed, funded and contracted. However, the dystrophies such as FSHD with complex etiology, low prevalence or that present unique scientific opportunity are getting far less funding than they deserve. FSHD is clearly deficient in projects and funding caused by it being a complicated disease with complex etiology that requires mastery to review grants or to undertake research. In the dystrophy area, the NIH believes that insight gained from studying a specific type of dystrophy will provide benefit for all of the muscular dystrophies. Sadly, that is not the case for FSHD.

NIH EFFORTS ON FSH MUSCULAR DYSTROPHY (2000-PRESENT)

NIH has supported several initiatives in recent years in dystrophy research and training. In response to the fiscal year 2000 report language, the NINDS, NIAMS and the NIH Office of Rare Diseases (ORD) held a research symposium in May 2000, in Bethesda, on the cause and treatment of FSH muscular dystrophy. The international team of researchers and NIH staff assembled research recommendations and directions that called for enhancing the understanding of the mechanism and molecular process associated with FSHD, strategies for exploring potential treatments and therapies, strategies to promote establishment of biomaterials registries and longitudinal and population based studies of FSHD, and a listing of required infrastructure and research resources.

The findings of the conference on FSHD were used to create NIH solicitations. One request focused on exploratory and high risk research applications on FSH muscular dystrophy, and several other announcements were made for grant applications on therapeutic and pathogenic approaches for muscular dystrophy in which FSHD was mentioned.

In September 2000, the NINDS and NIAMS issued a contract to establish and fund a National Registry for Myotonic and FSH Muscular Dystrophy based at the University of Rochester. Patients join the registry voluntarily by providing medical and family history data. The registry brings together FSHD patients and families seeking to participate in research with researchers seeking patients for research on the disorder.

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[1] NIH Action Plan for the Muscular Dystrophies, Mechanisms Section, Research Objective 3: "Define the molecular pathogenetic mechanisms that lead to facioscapulohumeral muscular dystrophy," December 2005.

"Defining the molecular mechanisms by which a reduction in repeats at the D4Z4 translates into the multi-system symptoms seen in facioscapulohumeral muscular dystrophy has been difficult. Elucidation of the function of the allelic variants (A and B) at D4Z4 may help advance understanding of disease mechanisms. If perturbations of chromatin structure and/or derepression of gene expression ultimately figure into pathogenesis, there are some other diseases that could help inform researchers in this field. A potentially important avenue of research is the analysis of the chromatin structure at the D4Z4 locus, including methylation and/or binding of specific repressors or activators. Such chromatin conformational changes have been suggested as a possible disease mechanism, presumably affecting the regulation of expression of other genes. Since the issue of altered regulation of genes in the vicinity of D4Z4 remains controversial, there is a need for careful studies using microarrays or other techniques, to determine if genes near the D4Z4 repeat units on chromosome 4q, or at more distant locations on this chromosome, are up-regulated or down-regulated in facioscapulohumeral muscular dystrophy. The expression and function of the D4Z4 gene, DUX4, should be analyzed. The association of 4qter with the nuclear lamina and the potential role of this association upon gene expression profiles should be explored. Genetic causes for facioscapulohumeral muscular dystrophy, other than the D4Z4 contraction (such as non-chromosome 4 linked cases), should be investigated in available patients."

Several program announcements were issued to promote large scale clinical and translational research in muscular dystrophy, as called for in the MD–CARE Act, called the Senator Paul D. Wellstone Muscular Dystrophy Research Centers. One of these centers, at the University of Rochester, focuses on myotonic and FSH muscular dystrophy. One-quarter of this Wellstone MD CRC center focuses on the molecular pathology of FSHD and serves as a resource for cell lines, tissue biopsies, antibodies and data about gene expression. This Wellstone MD CRC core at Rochester is the only funding specific for FSHD in the six Wellstone MD CRCs.

The MD–CARE Act provides that the Wellstone MD CRC centers are not to replace funding and projects in existing basic research portfolios. In addition to building national infrastructure for dystrophy research, the NIH is expanding research resources for FSHD by funding several basic research grants related to understanding the mechanism and pathology of FSH muscular dystrophy.

One of these grantees, Rossella Tupler, supported by the FSH Society, helped bring about a momentous breakthrough in FSHD research. The prestigious scientific journal Nature made an advance online publication of "Facioscapulohumeral muscular dystrophy in mice over-expressing FRG1", by Davide Gabellini and Rossella Tupler, et al., on December 11, 2005. The Nature paper is a breakthrough on multiple levels, it: (1) creates an animal model for FSHD; (2) points to a gene, called FRG1, that causes FSHD; (3) identifies other genetic processes impacted by FRG1 over-expression involved in other major adult dystrophies; (4) shows that both the FRG1 gene and mis-expressed pre-mRNA intermediary products can be targeted and regulated by new and novel gene therapy techniques to correct expression levels; and (5) gives FSHD the hard target needed in order have better success in securing major funding from large agencies. They have demonstrated that transcriptional modulation of a gene from the region can produce an interesting, potentially relevant phenotype. This model can now be used to create conditional variants and ultimately move on to look for transcriptional suppressors of the phenotype.

The NINDS, NIAMS and NICHD support career development and training awards for muscle biology and neuroscience through three program announcements for domestic and foreign investigators to help create a cadre of new scientists and researchers working on muscular dystrophy. The NINDS, NIAMS program officers in dystrophy are working diligently trying to help extramural researchers submit the highest quality applications.

The NIH assisted Dr. Melanie Ehrlich of Tulane University, who was displaced by hurricane Katrina by offering a position in the NIAMS intramural research laboratory of Dr. Kuan Wang and granting supplemental relief funds to salvage her FSHD research.

NIH MUSCULAR DYSTROPHY FUNDING

However, in the 6 years since the MD–CARE Act was signed the NIH [NIAMS, NINDS, NICHD, NHGRI] funding for FSHD remains very small. Since 2000, the overall NIH wide muscular dystrophy budget has increased from $12.6 million to $39.0 million in fiscal year 2007 estimated. Since 2000, the FSHD budget has increased from $400,000 to $2.1 million in fiscal year 2007 estimated. In the past year, at least five basic research grant applications (R01s) were submitted on FSHD and none were chosen for funding! Though the international field of FSHD researcher is small, the researchers are absolutely top-rate, world class and certainly competitive with other NIH grant applicants. Five applications represents about 25–30 percent of the entire field of FSHD researchers with the standing and experience to submit a basic research grant. A significant amount of FSHD researchers are submitting grant applications!

NATIONAL INSTITUTES OF HEALTH (NIH) APPROPRIATIONS HISTORY

[Dollars in millions]

Fiscal year	NIH overall	MD research	MD percent of NIH	FSHD research	FSHD percent of MD	FSHD percent of NIH
2000	$17,821	$12.60	0.071	$0.40	3.18	0.0022
2001	20,458	21.00	0.103	0.50	2.38	0.0024
2002	23,296	27.60	0.118	1.30	4.71	0.0056
2003	27,067	39.10	0.144	1.50	3.83	0.0055
2004	27,887	38.70	0.139	2.20	5.67	0.0079
2005	28,494	39.50	0.139	2.00	5.06	0.0070
2006	28,428	39.3E	0.138	2.1E	5.31	0.0074

NATIONAL INSTITUTES OF HEALTH (NIH) APPROPRIATIONS HISTORY—Continued

[Dollars in millions]

Fiscal year	NIH overall	MD research	MD percent of NIH	FSHD research	FSHD percent of MD	FSHD percent of NIH
2007E	28,428	39.0E	0.137	2.1E	5.38	0.0074

Source: NIH/OD Budget Office & NIH OCPL.

NIAMS has one research contract for FSHD, the National Registry for Myotonic and FSH muscular dystrophy for $295,888 (fiscal year 2005). Its total muscular dystrophy portfolio for fiscal year 2005 was 57 projects, including two Wellstone MD CRC components for a total of $17,136,343. FSHD was only 1.7 percent of NIAMS fiscal year 2005 muscular dystrophy funding.

NINDS reports three research grants, one intramural grant, one research contract, and one-quarter of a Wellstone CRC for FSHD for a total of $1,359,930 in fiscal year 2005. The total muscular dystrophy fiscal year 2005 portfolio reported for fiscal year 2005 was 33 projects, including two Wellstone CRCs for a total of $11,987,219. FSHD was only 11.4 percent of NINDS fiscal year 2005 muscular dystrophy funding.

NICHD reports that approximately ten percent of its $4,762,321 fiscal year muscular dystrophy portfolio has some broad or general application to FSHD, but does not identify specific projects. The NICHD reports that $400,000 was spent on FSHD. The total muscular dystrophy fiscal year 2005 portfolio reported was 17 projects, including three Wellstone MD CRC components for a total of $4,762,321. FSHD was only 8.4 percent of NICHD fiscal year 2005 dystrophy funding.

The NIAMS, NINDS, NICHD, and NHGRI—the four lead institutes on muscular dystrophy—reported a combined total of 108 projects on muscular dystrophy totaling $34,285,883 in fiscal year 2005. Of that total amount facioscapulohumeral muscular dystrophy (FSHD) received $1,440,555 in directly titled funds for three grants, one contract and one-quarter of a Wellstone MD CRC.

The NIH now has six Wellstone MD CRCs, which are approximately equivalent to 27 basic research grants (R01). One-quarter of one Wellstone, or one R01 equivalent, has direct relevance to FSHD. Only 3.7 percent of the total Wellstone MD CRC expenditure is being spent on the second most prevalent adult muscular dystrophy or the third most prevalent form of muscular dystrophy affecting men, women and children.

REQUEST

Mr. Chairman and Members of the Committee, we request an appropriation of $10 million–$12.5 million to accomplish the FSH muscular dystrophy research plan as outlined by the NIH and submitted to the Congress. As a start, simply examining the scope of the work outlined in the NIH Action Plan for Muscular Dystrophy "Mechanisms Section, Research Objective 3: Define the molecular pathogenetic mechanisms that lead to FSH muscular dystrophy," illustrates a requirement of at least 12 to 15 basic research grants (R01s) and/or high risk innovative research grants (R21s) that require $5 million–$6 million to adequately fund them.

We also request that the umbrella area of muscular dystrophy receive an appropriation commensurate with similar disease areas, and we request equity by starting with a doubling of the current $39 million to $80 million to adequately fund the NIH research plan for dystrophy. NIH Disease Funding, Special Areas of Interest table shows that similar umbrella areas of health burden, scope, and impact such as Multiple Sclerosis ($109 million), Motor Neuron Disease ($57 million), Cystic Fibrosis ($89 million), Parkinson's ($223 million), and Huntington's ($48 million) receiving average funding levels of $105 million. Muscular dystrophy affects hundreds of thousands of individuals, including family and friends.

We understand that the NIH overall budget went down in fiscal year 2006 to $28,428M from $28,494M and that Congress is strapped with other priorities. Chairman Specter, thank you for the constant and consistent support of biomedical research and for the NIH programs that offer hope for millions of sick and dying people. Mr. Chairman, members of the committee and members of Congress, the opportunities for FSHD research are greater than ever. The past year brought with it several major breakthroughs and discoveries and we are on the cusp of understanding FSHD and a never before seen class of disease. Now that we have a very refined plan of attack and research direction by the NIH, the need for funding is even greater. FSHD research needs to continue unabated and we remind you that there is no treatment or therapy for this devastating and crippling disease.

We ask the subcommittee to appropriate in fiscal year 2007 $12.5 million for FSH Muscular Dystrophy and $80 million for Muscular Dystrophy either as new money towards the overall NIH budget or as a requested allocation/re-allocation of resources internally within the NIH, to support the NIH stated plan of action to work on dystrophy. We thank the subcommittee for this opportunity to present our views.

PREPARED STATEMENT OF THE FOSTER GRANDPARENT PROGRAM

Mr. Chairman and members of the subcommittee, thank you for the opportunity to submit this testimony in support of fiscal year 2007 funding for the Foster Grandparent Program (FGP), the oldest and largest of the three programs known collectively as the National Senior Volunteer Corps, which are authorized by Title II of the Domestic Volunteer Service Act (DVSA) of 1973, as amended and administered by the Corporation for National and Community Service (CNS). NAFGPD is a membership-supported professional organization whose roster includes the majority of more than 350 directors, who administer Foster Grandparent Programs nationwide, as well as local sponsoring agencies and others who value and support the work of FGP.

Mr. Chairman, I would like to begin by thanking you and the distinguished members of the subcommittee for your steadfast support of the Foster Grandparent Program. No matter what the circumstances, this subcommittee has always been there to protect the integrity and mission of our programs. Our volunteers and the children they serve across the country are the beneficiaries of your commitment to FGP, and for that we thank you. I also want to acknowledge your outstanding staff for their tireless work and very difficult job they have to "make the numbers fit."—an increasingly difficult task in this budget environment.

NAFGPD remains concerned that the Corporation's fiscal year 2007 request does not provide any new funding where it is needed most—in the field. All of us recognize the spending constraints placed on the President and, most importantly on you and the Appropriations Committee. However, in a time of such scarce Federal resources, NAFGPD believes strongly that any new funding should flow to our programs in the field where it is most urgently needed, not CNCS headquarters.

This fiscal year 2007 budget request follows fiscal year 2006 in which FGP experienced a nearly $500,000 funding cut. The last time FGPs in the field realized any increases at all to cover the increased costs of doing business—especially in the area of transportation costs—was in fiscal year 2005; that increase amounted to a very small .84 percent, when inflationary price increases have been averaging 2–3 percent every year. FGP programs continue to face considerable stress in covering the rising costs of administering programs and maintaining program quality.

NAFGPD respectfully requests two things of the subcommittee:

(1) To provide $115.929 million for the Foster Grandparent Program in fiscal year 2007, an increase of $4.992 million over the fiscal year 2006 level. This critical funding will ensure the continued viability of the Foster Grandparent Program, and allow for important expansion of this unique program. Specifically, this proposal would fund a 3 percent cost of living increase for every Foster Grandparent Program and expansion grants to existing programs that would add 370 new low-income senior volunteers to serve children;

(2) To maintain current appropriations statutory language that prohibits CNCS from using funds in the bill to pay non-taxable stipend to volunteers whose incomes exceed 125 percent of the national poverty level. In its budget narrative, CNCS has again requested that this language be eliminated because it stifles innovation. In fact, CNCS has the ability to test any innovations they wish through demonstration activities—they just cannot pay a non-taxable stipend to volunteers whose incomes exceed 125 percent of the national poverty level. Congress has repeatedly over the last six years disavowed this practice and re-affirmed that the non-taxable stipend must be reserved for low-income volunteers. We ask that you again protect the mission of the Foster Grandparent and Senior Companion Programs—to enable low-income older people—to serve their communities by maintaining this important statutory language.

FGP: AN OVERVIEW

Established in 1965, the Foster Grandparent Program was the first federally funded, organized program to engage older volunteers in significant service to others. From the 20 original programs based totally in institutions for children with severe mental and physical disabilities, FGP now comprises nearly 350 programs in every State and the District of Columbia, Puerto Rico, and the Virgin Islands. These programs are now primarily in community-based child caring agencies or organiza-

tions—where most special needs children can be found today—and are administered locally through a non-profit organization or agency and Advisory Council comprised of community citizens dedicated to FGP and its mission. FGP represents the best in the Federal partnership with local communities, with Federal dollars flowing directly to local sponsoring agencies, which in turn determine how the funds are used. Through this partnership and the flexibility of the program, FGP is able to meet the immediate needs of the local communities. This was demonstrated by Foster Grandparent Programs in communities that were impacted by the influx of Hurricane Katrina evacuees. Foster Grandparents rallied to provide services to children in shelters, child care centers, and schools.

There are currently 38,700 Foster Grandparent volunteers who give over 36 million hours annually to more than 277,000 children. The Foster Grandparent Program is unique for several reasons. The program is one of only two volunteer programs in existence that enable seniors living on very limited incomes to serve their communities as volunteers by providing a small non-taxable stipend and other support which allow volunteers to serve at little or no cost to themselves. FGP volunteers provide intensive, consistent service—15 to 40 hours every week, usually four hours every day. FGP provides intensive pre-service orientation and at least 48 hours of ongoing training every year to keep volunteers current and informed on how to work with children who have special needs. And our volunteers provide one-to-one service to their assigned children, exactly what is required to help prepare our Nation's neediest children to become self-sufficient adults.

FGP: THE VOLUNTEERS

The Foster Grandparent Program is a versatile, dynamic, and uniquely multi-purpose program. First, the program gives Americans 60 years of age or older who are living on incomes at or less than 125 percent of the poverty level the opportunity to serve 15 to 40 hours every week and use the talents, skills and wisdom they have accumulated over a lifetime to give back to the communities which nurtured them throughout their lives. Seniors in general are not valued or respected in today's society, and low-income seniors are particularly devalued because of their economic status. They are rarely asked by their communities to contribute through volunteering, because they are not traditionally those who participate in community activities.

FGP actively seeks out these low-income seniors. We dare to ask them to serve, to give something back. And we help them to develop the additional skills they may need to function effectively in settings unfamiliar to them, like public schools, hospitals, childcare centers, and juvenile detention facilities. We also provide them with ongoing training and support throughout their tenure as Foster Grandparents. Through their service, our older volunteers say they feel and stay healthier, that they feel needed and productive. Most importantly, they leave to the next generation a legacy of skills, perspective and knowledge that has been learned the hard way—through experience.

Within budgetary constraints, FGP is engaging older people who are not usually asked to serve and those usually considered as needing services rather than being able to serve: 86 percent are 65 or older and 45 percent come from various ethnic groups.

FGP: THE CHILDREN

Through our volunteers, the Foster Grandparent Program also provides person-to-person service to children and youth under the age of 21 who have special or exceptional needs, many of whom face serious, often life-threatening challenges. With the changing dynamics in family life today, many children with disabilities and special needs lack a consistent, stable adult role model in their lives. The Foster Grandparent is very often the only person in a child's life who is there every day, who accepts the child, encourages him no matter how many mistakes the child makes, and focuses on the child's successes.

Special needs of children served by Foster Grandparents include AIDS or addiction to crack or other drugs; abuse or neglect; physical, mental, or learning disabilities; speech, or other sensory disabilities; incarceration and terminal illness. Of the children served, 7 percent are abused or neglected, 26 percent have learning disabilities, and 11 percent have developmental delays. FGP focuses its resources in areas where they will have the most impact: early intervention services and literacy activities. Nationally, 85 percent of the children served by Foster Grandparents are under the age of 12, with 39 percent of these children age 5 or under. Foster Grandparents work intensively with these very young children to address their problems at as early an age as possible, before they enter school. Nearly one-half of FGP vol-

unteers serve nearly 12 million hours annually addressing literacy and emergent-literacy problems with special needs children.

Activities of the FGP volunteers with their assigned children include teaching parenting skills to teen parents; providing physical and emotional support to babies abandoned in hospitals; helping children with developmental, speech, or physical disabilities develop self-help skills; reinforcing reading and mathematics skills; and giving guidance and serving as mentors to incarcerated or other youth.

FGP: THE VOLUNTEER SITES

The Foster Grandparent Program provides child-caring agencies and organizations offering services to special-needs children with a consistent, reliable, invaluable extra pair of hands 15 to 40 hours every week to assist in providing these services. Seventy-one percent of FGP volunteers serve in public and private schools as well as sites that provide early childhood pre-literacy services to very young children, including Head Start.

FGP: COST-EFFECTIVE SERVICE

The Foster Grandparent Program serves local communities in a high quality, efficient and cost-effective manner, saving local communities money by helping our older volunteers stay independent and healthy and out of expensive in-home or institutional care. Using the Independent Sector's 2003 valuation for one hour of volunteer service ($17.19/hour), the value of the service given by Foster Grandparents annually is over $618 million, and represents a 5-fold return on the Federal dollars invested in FGP. The annual Federal cost for one Foster Grandparent is $3,800—less than $4 per hour.

The value local communities place on FGP and its multifaceted services is evidenced by the large amount of cash and in-kind donations contributed by communities to support FGP. For example, FGP's fiscal year 2001 Federal allocation was matched with $40 million in non-Federal donations from States and local communities in which Foster Grandparents volunteer. This represents a non-Federal match of 42 percent, or $.42 for every $1 in Federal funds invested—well over the 10 percent local match required by law.

NAFGPD'S FISCAL YEAR 2007 BUDGET REQUEST

Given the dramatically expanding number of low-income seniors eligible to serve and the staggering number of troubled and challenged children in America today, we respectfully request that the subcommittee provide $115.929 million for the Foster Grandparent Program in fiscal year 2007, an increase of $4.992 million over fiscal year 2006. This critical funding will ensure the continued viability of the Foster Grandparent program, and allow for an expansion of this important program.

The requested increase would be allocated for the following purposes, in order of priority:

1. in accordance with the Domestic Volunteer Service Act (DVSA), designate one-third of the increase over the fiscal year 2006 level to fund Program of National Significance (PNS) expansion grants to allow existing FGP programs to expand the number of volunteers serving in areas of critical need as identified by Congress in the DVSA. This expansion of FGP was overwhelmingly supported and endorsed by White House Conference in Aging delegates at the recent 2005 Conference convened by the President.

2. use all remaining funds to award an administrative cost increase of at least 3 percent to each existing Foster Grandparent Program in order to maintain quality, enable recruitment and sustain the work already being done by programs.

This funding proposal will generate opportunities for approximately 370 new low-income senior volunteers to contribute 390,000 hours of service annually to nearly 2,000 additional children with special needs through PNS grants to existing FGPs.

We request that no funds be provided for Senior Demonstration. Language in the Corporation for National and Community Service's Budget Justification indicate that any demonstration funds awarded will again be used for programming that allows the payment of a stipend to individuals whose incomes exceed 125 percent of the national poverty level. In recognition of the fact that this practice has nothing to do with the true spirit of volunteerism, Congress has expressly prohibited this practice for the last 6 years in appropriations language; we request that this important language be maintained to protect the purpose of FGP and SCP: to enable low-income elders to serve their communities.

The message is clear: (1) the population of low-income seniors available to volunteer 15 to 40 hours every week is increasing; (2) communities need and want more Foster Grandparent volunteers and more Foster Grandparent Programs. The sub-

committee's continued investment in FGP now will pay off in savings realized later, as more seniors stay healthy and independent through volunteer service, as communities save tax dollars, and as children with special needs are helped to become contributing members of society.

Mr. Chairman, in closing I would like to again thank you for the subcommittee's support and leadership for FGP over the years. NAFGPD takes great comfort in knowing you and your colleagues in Congress appreciate what our low-income senior volunteers accomplish every day in communities across the country.

PREPARED STATEMENT OF FRIENDS OF THE NATIONAL INSTITUTE ON AGING

Chairman Specter and members of the subcommittee, thank you for this opportunity to testify in support of increasing funding within the National Institutes of Health (NIH), and in particular within the National Institute on Aging (NIA).

The Friends of the NIA is a relatively new coalition comprised of some 50 organizations from academia and the non-profit community. All of the groups comprising the Friends of the NIA conduct, fund or advocate for scientific efforts to improve the health and quality of life for Americans as they grow older. All of our groups support the continuation and expansion of biomedical, behavioral, and social science research within the NIA. The Friends of the NIA seeks to raise awareness about aging research and the important scientific progress supported and guided by the NIA. Our testimony not only addresses recent research advances funded by the NIA, but also points to missed opportunities if there is not growth in the NIA appropriation from Congress in fiscal year 2007.

The NIA is dedicated to conducting biomedical, behavioral, and social science research in order to prevent disease and other problems of the aged, and to maintain the health and independence of older Americans. This research is all the more urgent because of the explosive growth of the older population in the United States. This year, the first wave of our largest generation—some 77 million members of the postwar Baby Boom generation—began turning aging 60. Currently there are some 36 million Americans aged 65 and older. That population is expected to double in size within the next 25 years, at which time nearly 20 percent of the American population will be older than age 65 and eligible for old age assistance for health care under the Federal Medicare program (Federal Interagency Forum on Aging-Related Statistics 2004, Older Americans). Of particular interest is the dramatic growth that is anticipated among those most at risk for disease and disability, people age 85 and over whose numbers are expected to grow from 4.3 million in 2000 to at least 19.4 million in 2050 (65+ in the United States: 2005, U.S. Census, 2006).

This growing population presents many social and economic challenges as increasing numbers of Americans reach retirement age. This rapidly expanding population, many of whom will have multiple medical needs, will require substantial changes in health care delivery. Aging itself is not the cause of disease, disability, and frailty, but these conditions are influenced by age-related changes, lifestyle choices and rising risk factors. We also know that outside influences, such as economic, physical, environmental, and caregiving stresses increase vulnerability to disease, especially amongst the elderly. NIA has a broad research portfolio and is the only Institute that studies the normal changes associated with aging as well as pathological conditions from an interdisciplinary perspective. Understanding when and how changes occur as we age provides important clues for developing interventions that will prevent and treat diseases, and improve quality of life.

In addition to participating in NIH-wide initiatives, NIA has made and supported many significant contributions of its own to the biomedical and psycho-social understanding of the aging processes and, through ongoing clinical trials, to the testing of promising interventions for the detection, treatment and prevention of many age-related conditions.

The NIA is the lead Federal research agency for Alzheimer's disease (AD). AD is the most common cause of dementia and a serious threat to the Nation's health and economic well-being. Today, an estimated 4.5 million Americans, 1 in 10 persons over age 65 and nearly one-half of those over 85, suffer from this debilitating disease. That toll is projected to increase to 5.1 million people by 2010 and 16 million by 2050 (Hebert et al. 2003, Alzheimer's Disease in the U.S. Population). Over the next decade, Medicare spending on beneficiaries with AD will more than triple to $189 billion. Our concern is that flattened budgets for the NIH institutes are threatening major AD research initiatives. One example is the Alzheimer's Disease Neuroimaging Initiative (ADNI), launched in 2004 as a public/private partnership: the most comprehensive effort to date to identify neuroimaging strategies and biomarkers to identify the onset of mild cognitive impairment and early AD with great-

er sensitivity. The project currently involves approximately 50 sites across the United States and Canada and holds the promise of early diagnosis and subsequent interventions that could postpone or more effectively treat AD. The Genetics Initiative is another multi-site collaboration that is collecting, sharing, and analyzing data to complete the picture of genetic risk factors for AD. These programs offer enormous potential to identify AD and intervene early, but lack of adequate funding will prevent or slow realization of the full potential of these programs. With aging baby boomers on the horizon, we cannot afford this delay.

Great strides have been made in AD. Only a few years ago, this disease could not be positively confirmed until autopsy. Now we can diagnose the disease in life with a high degree of certainty; we understand some of the basic mechanisms of the disease; and five approved drugs for treating symptoms are now approved with many new compounds being tested in publicly and industry-supported clinical trials.

This is a critical time for investment not retrenchment. Scientists are poised to find effective ways to prevent, delay onset, and even treat this disease. If the onset of AD could be delayed by just two years, the AD afflicted population would remain at current size, even with the expected increases in senior population; a five-year delay of onset would cut the projected AD population in half.

Other promising NIA biomedical research efforts into prominent diseases include research programs to discover new Parkinson's susceptibility genes; studies of age-related bone loss and osteoporosis; development of programs to assess genetic and environmental factors in racial and ethnic health differences simultaneously; and bone marrow failure diseases, all of which occur in higher incidence in people over 60.

NIA's behavioral and social science research programs have been instrumental in providing crucial economic and demographic population information. NIA's Centers on the Demography of Aging, particularly their Health and Retirement Survey (HRS) and the National Long-Term Care Survey (NLTCS), provide critical data on the health and economic status of the older population. These data have been used by Congress to better understand the budgetary impact of population aging, as potential changes to public programs such as Social Security, Medicare, and Medicaid are deliberated. By using NLTCS data, investigators identified the declining rate of disability in older Americans first observed in the mid-1990s—a trend that has continued. This trend, if continued, could have momentous impact on reducing the need for costly long-term care. The Social Security Administration recognizes and co-funds the HRS as a "Research Partner" and posts the study on its home page to improve its availability to the public and to policymakers. In 2005, the Center for Medicare and Medicaid Services (CMS) funded a supplemental survey using the HRS to provide timely information on who is likely to enroll in the new Medicare Part D prescription drug program and how those decisions are related to knowledge of the program, drug use and costs.

There is building evidence that continued engagement in productive activities has a positive impact on health and life satisfaction. The experience and expertise of the new 65+ population offers great potential to help address workforce shortages as well as some of the critical social needs of our country. The NIA is working to build a research agenda that focuses on maximizing older workers' safety, health, productivity and life satisfaction—knowledge that this will be critical to developing sound national policies.

NIA provides critical support for the training of new investigators. The reduction in funded proposals as a result of limited NIA budget will impact the ability to recruit and sustain an appropriate pool of qualified researchers in gerontology and geriatrics. Numerous reports have cited the need for more geriatricians and geriatric-trained professionals for our aging society. By 2030, the United States will need up to 36,000 geriatricians and will fall far short of that figure by as many as 25,000 unless effective steps are taken to train new providers (Medical Never-Never Land, Alliance for Aging Research, 2002). Further budget cuts will reduce funding available for training, and may force some leading researchers and practitioners to abandon gerontology as well as the mentoring of new professionals in the field.

With bipartisan leadership in Congress, the NIH budget doubled between 1998 and 2003 ($13.6 to $27.3 billion). However, since 2003, funding for the NIH in real dollars has been on a downward trajectory. Under the President's proposed fiscal year 2007 budget, the NIA is slated to be decreased in real terms by $10 million. Further, in order to preserve clinical trials already underway, NIA will fund only 18 percent of new grant proposals. This is down substantially from 28.5 percent in 2003, and will not come close to supporting the more than 50 percent of submitted applications that the NIA has determined to be highly promising. At the same time that the acceptance rate of new proposals is down, the funding levels of new grants has also dropped from years past. Moreover, even those grantees receiving funding

face an average reduction from requested budgets by 18 percent across the board. (Fiscal Year 2007, National Institutes on Aging, Justification of Estimates for Appropriations Committees). Investigator-initiated research projects provide new breakthroughs in knowledge and treatment to benefit older Americans and their families. Declining budgets slow momentum and impact future research programs. For example, continued cuts will impact projects such as, the start up of new clinical trials in caloric restriction, testosterone supplementation in men, and lifestyle interventions and independence for elders, all of which have shown great potential for significant public health outcomes.

The Friends of the National Institute on Aging recommend the following directives:

(1) The time for research on aging is now if we are to achieve a healthier and more productive aging America. To further this goal, the Friends of the NIA endorse the recommendation issued by the Ad Hoc Group for Medical Research in calling for a 5 percent overall increase for the National Institutes of Health in fiscal year 2007.

(2) NIA needs additional resources to support individual investigator awards, to avoid an 18 percent cut in its existing grants, and to sustain training and research opportunities for new investigators.

Mr. Chairman, the Friends of the NIA thanks you for this opportunity to outline the challenges threats and opportunities that lie ahead as you consider appropriate funding for the NIH and the National Institute on Aging.

PREPARED STATEMENT OF FRIENDS OF NIDA COALITION

The Friends of the National Institute on Drug Abuse (FoN), a burgeoning coalition of scientific and professional societies, patient groups, and other organizations committed to preventing and treating substance use disorders as well as understanding the causes and public health consequences of addiction, is pleased to provide testimony in support of the NIDA's extraordinary work. Pursuant to clause 2(g)4 of House Rule XI, the Coalition does not receive any Federal funds.

Drug abuse is costly—to individuals and to our society as a whole. Smoking, alcohol abuse and illegal drugs cost this country more than $500 billion a year, with illicit drug use alone accounting for about $180 billion in health care, crime, productivity loss, incarceration, and drug enforcement. Beyond its monetary impact, drug and alcohol abuse tear at the very fabric of our society, often spreading infectious diseases and bringing about family disintegration, loss of employment, failure in school, domestic violence, child abuse, and other crimes. The good news is that treatment for drug abuse is effective and recovery from addiction is real for millions of Americans across the country. Preventing drug abuse and addiction and reducing these myriad adverse consequences in the ultimate aim of our Nation's investment in drug abuse research. Over the past three decades, scientific advances resulting from research have revolutionized our understanding of and approach to drug abuse and addiction.

NODA supports a comprehensive research portfolio that spans the continuum of basic neuroscience, behavior and genetics research through applied health services research and epidemiology. While supporting research on the positive effects of evidence-based prevention and treatment efforts, NIDA also recognizes the need to keep pace with emergent problems. Research shows encouraging trends that NIDA's public education and awareness efforts are having an impact: For example, the 2005 Monitoring the Future Survey of 8th, 10th, and 12th graders shows a dramatic 19 percent reduction in use since 2001. However, areas of significant concern remain. Some of NIDA's current research priorities include understanding more about methamphetamine and the brain, addressing the growing problem of prescription drug abuse, using drug abuse treatment to curtail the spread of HIV/AIDS, and encouraging collaborations that address comorbidity.

Because of the critical importance of drug abuse research for the health and economy of our Nation, we write to you today to request your support for a 5 percent increase for NIDA in the fiscal 2007 Labor, Health and Human Services, Education and Related Agencies Appropriations bill. That would bring total funding for NIDA in fiscal 2007 to $1,050,030,450. Recognizing that so many health research issues are inter-related, we also support a 5 percent increase for the National Institutes of Health overall, which would bring its total to $30 billion for fiscal 2007, This work deserves continuing, strong support from Congress. Below is a short list of significant NIDA accomplishments, challenges, and successes.

Adolescent Brain Development—How Understanding the Brain Can Impact Prevention Efforts.—NIDA maintains a vigorous developmental research portfolio fo-

cused on adolescent populations. NIDA working collaboratively with other NIH Institutes has shown that the human brain does not fully develop until about age 25. This adds to the rationale for referring to addiction as a "developmental disease;" it often starts during the early developmental stages in adolescence and sometimes as early as childhood, a time when we know the brain is still developing. Having insight into how the human brain works, and understanding the biological underpinnings of risk taking among young people will help in developing more effective prevention programs. FoN believes NIDA should continue its emphasis on studying adolescent brain development to better understand how developmental processes and outcomes are affected by drug exposure, the environment and genetics.

Medications Development.—NIDA has demonstrated leadership in the field of medications development by partnering with private industry to develop anti-addiction medications resulting in a new medication, buprenorphine, for opiate addiction. FoN recommends that NIDA continue its work with the private sector to develop much needed anti-addiction medications, for cocaine, methamphetamine, and marijuana dependence.

Co-Occurring Disorders.—NIDA recognizes the need to to adequately address research questions related to co-occurring substance abuse and mental health problems. In particular, NIDA has developed robust collaborations with other agencies (such as NIAAA, NIMH and SAMHSA) to stimulate new research to develop effective strategies and to ensure the timely adoption and implementation of evidence-based practices for the prevention and treatment of co-occurring disorders. Through these initiatives, NIDA is supporting research to determine the most effective models of clinically appropriate treatment and how to bring them to communities with limited resources. FoN recognizes the imperative for continued funding of essential research into the nature of and improved treatment for these complex disorders and endorses these efforts.

Drug Abuse and HIV/AIDS.—One of the most significant causes of HIV virus acquisition and transmission involves drug taking practices and related risk factors in different populations (e.g. criminal justice, pregnant women, minorities, and youth). Drug abuse prevention and treatment interventions have been shown to be effective in reducing HIV risk. FoN congratulates NIDA on its "Drug Abuse and HIV—Learn the Link" public awareness campaign, targeting young people, and believes NIDA should continue to support research that focuses on developing and testing drug-abuse related interventions designed to reduce the spread of HIV/AIDS.

Emerging Drug Problems.—NIDA recognizes that drug use patterns are constantly changing and expends considerable effort to monitor drug use trends and to rapidly inform the public of emerging drug problems. FoN believes NIDA should continue supporting research that provides reliable data on emerging drug trends, particularly among youth and in major cities across the country and will continue its leadership role in alerting communities to new trends and creating awareness about these drugs.

Reducing Prescription Drug Abuse.—NIDA research has documented continued increases in the numbers of people, especially young people, who use prescription drugs for non-medical purposes. Particular concern revolves around the inappropriate use of opiod analgesics—very powerful pain medications. FoN commends NIDA for its research focus in this area, and for the new Prescription Opioid Use and Abuse in the Treatment of Pain initiative. Research targeting a reduction in prescription drug abuse, particularly among our Nation's youth, will continue to be a priority for NIDA. Finally, FoN endorses NIDA's programmatic research designed to further the development of medications that are less likely to have abuse/addiction liability, and to develop prevention and treatment interventions for adolescents and adults who are abusing prescription drugs.

Reducing Methamphetamine Abuse.—NIDA continues to recognize the epidemic abuse of methamphetamine across the United States. Methamphetamine abuse not only affects the users, but also the communities in which they live, especially due to the dangers associated with its production. FoN believes NIDA should continue to support research to address the broad medical consequences of methamphetamine abuse, and is encouraged by the evidence of treatment effectiveness in these populations. Topics of particular concern include: understanding the effects of prenatal exposure to methamphetamine, developing pharmacotherapies and behavioral therapies to treat methamphetamine addiction and information dissemination strategies to inform the public that treatment for methamphetamine addiction is effective.

Reducing Inhalant Abuse.—FoN recognizes that inhalant use continues to be a significant problem among our youth. Inhalants pose a particularly significant problem since they are readily accessible, legal, and inexpensive. They also tend to be abused by younger teens and can be highly toxic and even lethal. FoN applauds

NIDA's inhalant research portfolio and believes NIDA should continue its support of research on prevention and treatment of inhalant abuse, and to enhance public awareness on this issue.

Long-Term Consequences of Marijuana Use.—NIDA research shows that marijuana can be detrimental to educational attainment, work performance, and cognitive function. However, more information is needed in order to assess the full impact of long-term marijuana use. Therefore, FoN recommends that NIDA continue to support efforts to assess the long-term consequences of marijuana use on cognitive abilities, achievement, and mental and physical health, as well as work with the private sector to develop medications focusing on marijuana addiction.

Translating Research Into Practice.—FoN commends NIDA for its outreach and work with State substance abuse authorities to reduce the current 15- to 20-year lag between the discovery of an effective treatment intervention and its availability at the community level. In particular, FoN applauds NIDA for continuing its work with SAMHSA to strengthen State substance abuse agencies' capacity to support and engage in research that will foster statewide adoption of meritorious science-based policies and practices. FoN encourages NIDA to continue collaborative work with State substance abuse agencies to ensure that research findings are relevant and adaptable by State substance abuse systems. NIDA is also to be congratulated for its broad and varied information dissemination programs as part of an effort to ensure drug abuse research is used in everyday practice. The Institute is focused on stimulating and supporting innovative research to determine the components necessary for adopting, adapting, delivering, and maintaining effective research-supported policies, programs, and practices. As evidence-based strategies are developed, FoN urges NIDA to support research to determine how these practices can be best implemented at the community level.

Primary Care Settings and Youth.—NIDA recognizes that primary care settings, such as offices of pediatricians and general practitioners, are potential key points of access to prevent and treat problem drug use among young people; yet primary care and drug abuse services are commonly delivered through separate systems. FoN encourages NIDA to continue to support health services research on effective ways to educate primary care providers about drug abuse; develop brief behavioral interventions for preventing and treating drug use and related health problems, particularly among adolescents; and develop methods to integrate drug abuse screening, assessment, prevention and treatment into primary health care settings.

Utilizing Knowledge of Genetics and New Technological Advances to Curtail Addiction.—NIDA recognizes that not everyone who takes drugs becomes addicted and that this is an important phenomenon worthy of further exploration. Research has shown that genetics plays a critical role in addiction, and that the interplay between genetics and environment is crucial. The science of genetics is at a crucial phase—technological advances are providing the tools to make significant breakthroughs in disease research. For example, FoN believes NIDA should take advantage of new high-resolution genetic technologies which may help to develop new tailored treatments for smoking.

Reducing Health Disparities.—NIDA research demonstrates that the consequences of drug abuse disproportionately impacts minorities, especially African American populations. FoN believes that researchers should be encouraged to conduct more studies in this population and to target their studies in geographic areas where HIV/AIDS is high and or growing among African Americans, including in criminal justice settings.

The Clinical Trials Network—Using Infrastructure to Improve Health.—FoN applauds the continued success of NIDA's National Drug Abuse Treatment Clinical Trials Network (CTN), which was established in 1999 and has grown to include over 17 research centers or nodes spread across the country. The CTN provides an infrastructure to test the effectiveness of new and improved interventions in real-life community settings with diverse populations, enabling an expansion of treatment options for providers and patients. FoN suggests NIDA continue to develop ways to use the CTN as a vehicle to address emerging public health needs.

Behavioral Science.—NIDA has long demonstrated a strong commitment to supporting behavioral science research. FoN encourages NIDA to continue to determine the interplay of behavioral, biological, and social factors that affect development and the onset of diseases like drug addiction to understand common pathways that may underlie other compulsive behaviors such as gambling and eating disorders.

Drug Treatment in Criminal Justice Settings.—NIDA is very concerned about the well-known connections between drug use and crime. Research continues to demonstrate that providing treatment to individuals involved in the criminal justice system decreases future drug use and criminal behavior, while improving social functioning. Blending the functions of criminal justice supervision and drug abuse treat-

ment and support services create an opportunity to have an optimal impact on behavior by addressing public health concerns while maintaining public safety. FoN strongly supports NIDA's efforts in this area, particularly the Criminal Justice Drug Abuse Treatment Studies (CJ–DATS), a multi-site set of research studies designed to improve outcomes for offenders with substance use disorders by improving the integration of drug abuse treatment with other public health and public safety systems.

Social Neuroscience.—Research-based knowledge about the dynamic interactions of genes with environment confirm addiction as a complex and chronic disease of the brain with many contributors to its expression in individuals. FoN applauds NIDA's involvement in the recently released "social neuroscience" request for applications, and encourages the Institute to continue its focus on the interplay between genes, environment, and social factors and their relevance to drug abuse and addiction.

Translational Research: Ensuring Research is Adaptable and Useable.—FoN commends NIDA for its broad and varied information dissemination programs. FoN also understands that the Institute is focused on stimulating and supporting innovative research to determine the components necessary for adopting, adapting, delivering, and maintaining effective research-supported policies, programs, and practices. As evidence-based strategies are developed, FoN urges NIDA to support research to determine how these practices can be best implemented at the State and community level.

Blending Research and Practice.—FoN notes that it takes far too long for clinical research results to be implemented as part of routine patient care, and that this lag in diffusion of innovation is costly for society, devastating for individuals and families, and wasteful of knowledge and investments made to improve the health and quality of people's lives. FoN applauds NIDA's collaborative approach aimed at proactively involving all entities invested in changing the system and making it work better. NIDA is leading efforts to make the best substance abuse treatments available to those who need them, and this effort requires working with many different contributors to assimilate their feedback and create change at multiple levels.

CONCLUSION

The Nation's investment in scientific research has changed the way people view drug abuse and addiction in this country. We now know how drugs work in the brain, their health consequences, how to treat people already addicted, and what constitutes effective prevention strategies. FoN asks you to provide an appropriation of $1,050,030,450 for NIDA, so that it may continue to serve the public health of all Americans and capitalize on new opportunities as science advances.

We understand that the fiscal year 2007 budget cycle will involve setting priorities and accepting compromise. However, in the current climate, we believe a focus on substance abuse and addiction, which according to the World Health Organization account for nearly 20 percent of disabilities among 15–44 year olds, deserve to be prioritized accordingly. We look forward to working with you to make this a reality.

Thank you, Mr. Chairman, and the subcommittee, for your support for the National Institute on Drug Abuse.

PREPARED STATEMENT OF THE HEART RHYTHM SOCIETY

The Heart Rhythm Society (HRS) thanks you and the Subcommittee on Labor, Health and Human Services and Education for your past and continued support of the National Institute of Health, and specifically the National Heart, Lung and Blood Institute (NHLBI).

The Heart Rhythm Society, founded in 1979 to address the scarcity of information about the diagnosis and treatment of cardiac arrhythmias, is the international leader in science, education and advocacy for cardiac arrhythmia professionals and patients, and the primary information resource on heart rhythm disorders. The Heart Rhythm Society serves as an advocate for millions of American citizens from all 50 States, since arrhythmias are the leading cause of heart-disease related deaths. Other, less lethal forms of arrhythmias are even more prevalent, account for 14 percent of all hospitalizations of Medicare beneficiaries.[1] Our mission is to improve the care of patients by promoting research, education and optimal health care policies

[1] Heart Rhythm Foundation, Arrhythmia Key Facts, 2004 http://www.heartrhythmfoundation.org/facts/arrhythmia.asp.

and standards. We are the preeminent professional group, representing more than 4,200 specialists in cardiac pacing and electrophysiology.

The Heart Rhythm Society recommends the subcommittee renew its commitment to supporting biomedical research in the United States and recommends Congress provide NIH with a 5 percent increase for fiscal year 2007. This translates into an appropriation of $29.849 billion for NIH, with $3.068 billion designated to the National Heart, Lung, and Blood Institute (NHLBI). This increase will enable NIH and NHLBI to sustain the level of research that leads to research breakthroughs and improved health outcomes. In particular, the Heart Rhythm Society recommends Congress support research into abnormal rhythms of the heart.

HRS appreciates the actions of Congress to double the budget of the NIH in recent years. The doubling has directly promoted innovations that have improved treatments and cures for a myriad of medical problems facing our Nation. Medical research is a long-term process and in order to continue to meet the evolving challenges of improving human health we must not let our commitment wane. Furthermore, NIH research fuels innovation that generates economic growth and preserves our Nation's role as a world leader in the biomedical and biotech industries. Healthier citizens are the key to robust economic growth and greater productivity. Economists estimate that improvements in health from 1970 to 2000 were worth $95 trillion. During the same time period, the United States invested $200 billion in the NIH. If only 10 percent of the overall health savings resulted from NIH-funded research, our investment in medical research has provided a 50-fold return to the economy.[2]

RESEARCH ACCOMPLISHMENTS

In the field of cardiac arrhythmias, NIH-funded research has advanced our ability to treat atrial fibrillation and thus prevent the devastating complications of stroke. Atrial fibrillation is found in about 2.2 million Americans and increases the risk for stroke about 5-fold. About 15–20 percent of strokes occur in people with atrial fibrillation. Stroke is a leading cause of serious, long-term disability in the United States and people who have strokes caused by AF have been reported as 2–3 times more likely to be bedridden compared to those who have strokes from other causes. Each year about 700,000 people experience a new or recurrent stroke and in 2002 stroke accounted for more than 1 of every 15 deaths in the United States. Ablation therapy however is providing a cure for individuals whose rapid heart rates had previously incapacitated them, giving them a new lease on life.[3]

Important advances have also been made in identifying patients with heart failure and those who have suffered a heart attack and are at risk for sudden death. The development, through initial NIH-sponsored research, and implantation of sophisticated internal cardioverter defibrillators (ICD's) in such patients has saved the lives of hundreds of thousands and provides peace of mind for families everywhere, including that of Vice-President Cheney's. A new generation of pacemakers and ICDs is restoring the beat of the heart as we grow older, permitting us to lead more normal and productive lives, reducing the burden on our families, communities and the healthcare system. Arrhythmias and sudden death affect all age groups and are not solely diseases of the elderly.

Research advances in molecular genetics have provided us the root basis for life-threatening abnormal rhythms of the heart associated with of wide range of inherited syndromes including long and short QT, Brugada syndromes, and hypertrophic cardiomyopathies. This knowledge has provided guidance to physicians for better detection and treatment of these sudden death syndromes reducing mortality and disability of infants, children and young adults. Individuals who survive an instance of sudden death often remain in vegetative states, resulting in a devastating burden on their families and an enormous economic burden on society. These advances have translated into sizeable savings to the health care system in the United States. Researchers are also developing a noninvasive imaging modality for cardiac arrhythmias. Despite the fact that more than 325,000 Americans die every year from heart rhythm disorders, a noninvasive imaging approach to diagnosis and guided therapy of arrhythmias, the equivalent of CT or MRI, has previously not been available.

The NIH-funded Public Access Defibrillation (PAD) Trial was also able to determine that trained community volunteers increase survival for victims of cardiac arrest. It had already been known that defibrillation, utilizing an automated external

[2] Murphy, KM and Topel, RH, The Value of Health and Longevity, National Bureau of Economic Research Working Paper Series, Working Paper 11405, June 2005.

[3] American Stroke Association and American Heart Association, Heart Disease and Stroke Statistics—2005 Update, 2005 http://www.americanheart.org/downloadable/heart/1105390918119HDSStats2005Update.pdf.

defibrillator (AED), by trained public safety and emergency medical services personnel is a highly effective live-saving treatment for cardiac arrest. A NIH-funded trial however was able to conclude that placing AED's in public places and training lay persons to use them can prevent additional deaths and disabilities.[4]

Without NIH support, these life-saving findings may have taken a decade to unravel. The highly focused approach utilizing basic and clinical expertise, funded through Federal programs made these advances a reality in a much shorter timeperiod.

BUDGET JUSTIFICATION

These impressive strides notwithstanding, cardiac arrhythmias continue to plague our society and take the lives of loved ones at all ages, nearly one every minute of every day, as well as straining an already burdened health system. Sudden Cardiac Arrest is a leading cause of death in the United States, claiming an estimated 325,000 lives every year, or one life every two minutes.[5] The burden of morbidity and mortality due to cardiac arrhythmias is predicted to grow dramatically as the baby boomers age. Atrial fibrillation strikes 3–5 percent of people over the age of 65,[6] presenting a skyrocketing economic burden to our society in the form of healthcare treatment and delivery. It is estimated in 2005 that the direct and indirect cost of stroke will be $56.8 billion.[7] Cardiac diseases of all forms increase with advancing age, ultimately leading to the development of arrhythmias. NIH research provides the basis for the medical advances that hold the key to lowering health care costs.

The above progress we have witnessed in recent years will provide treatments for this illness, only if the resources continue to be available to the academic scientific and medical community. However, the budgets appropriated by Congress to the NIH in the past three years were far below the level of scientific inflation. These vacillations in funding cycles threaten the continuity of the research and the momentum that has been gained over the years. While HRS recognizes that Congress must balance other priorities, sustaining multi-year growth for the biomedical research enterprise is critical. A central objective of the doubling of the NIH budget was to accelerate solutions to human disease and disability. NIH is now engaging in the next generation of biomedical research to translate basic research and clinical evidence into new cures. Our ability to bring together uniquely qualified and devoted investigators and collaborators both at the basic science level and in the clinical arena is a vital key to our to this success. Funding models however show that a threshold exists, below which NIH will not be able to maintain its current scope and number of grants, let alone expand its programs to address new concerns and emerging opportunities. Furthermore, the United States is in danger of losing its leadership role in science and technology. The United States faces growing competition from other nations, such as China and India, which are working to invest more of their GDP's into building state-of-the-art research institutes and universities to foster innovation and compete directly for the world's top students and researchers.[8]

It is for this reason that we are asking for your support to increase NIH appropriations by 5 percent for a fiscal year 2007 budget of $29.849 billion for NIH and $3.068 billion for NHLBI. The Heart Rhythm Society recommends Congress specifically acknowledge the need for cardiac arrhythmia research to prevent sudden cardiac arrest and other life threatening conditions such as sudden infant death syndrome, definitive therapeutic approaches for atrial fibrillation and the prevention of stroke, and other genetic arrhythmia conditions. Thank you very much for your consideration of our request.

If you have any questions or need additional information, please contact Nevena Minor, Coordinator, Health Policy at the Heart Rhythm Society (amelnick@hrsonline.org or 202–464–3434).

Thank you again for the opportunity to submit testimony.

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[4] National Heart Lung and Blood Institute, NIH, Public Access Defibrillation by Trained Community Volunteers Increases Survival for Victims of Cardiac Arrest, November 2003 http://www.nhlbi.nih.gov/new/press/03__11__11.htm.

[5] Heart Rhythm Foundation, The Facts on Sudden Cardiac Arrest, 2004 http://www.heartrhythmfoundation.org/its__about__time/pdf/provider__fact__sheet.pdf.

[6] Heart Rhythm Society, Atrial Fibrillation & Flutter, 2005__ttp://www.hrspatients.org/patients/heart__disorders/atrial__fibrillation/default.asp.

[7] American Stroke Association, Impact of Stroke, 2005 http://www.strokeassociation.org/presenter.jhtml?identifier=1033.

[8] Task Force on the Future of American Innovation, The Knowledge Economy: Is the United States Losing it's Competitive Edge?, February 16, 2005.

PREPARED STATEMENT OF THE HEMOPHILIA FEDERATION OF AMERICA

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS

—Continued support for Hemophilia Treatment Centers through the Health Resources and Services Administration Maternal and Child Health Block Grant.
—$10 million for hemophilia programs at the Centers for Disease Control and Prevention and expansion of the program to allow partnerships with additional patient-based organizations within the hemophilia community.
—A 5 percent increase overall for the National Institutes of Health, including a 5 percent increase for the National Heart, Lung, and Blood Institute, and the National Institute for Allergy and Infectious Diseases.

INTRODUCTION

The Hemophilia Federation of America (HFA) is a national nonprofit organization that assists and advocates for the blood clotting disorders community. The vision of the HFA is that the blood clotting disorders community will face no barriers to choice of treatment and quality of life.

The programming of HFA is designed to be of assistance to the consumer and their families and is structured to follow our mission and vision. We at HFA consider ourselves the "consumer organization." That was the purpose of our organization when we were established a decade ago and it has remained constant in the structure and activities of the organization. The following is a summary of some of the programs that HFA offers to the hemophilia community:

"Helping Hands"

Helping Hands is a program that offers financial assistance to patients and families in a crisis. The grant applicant requests funds for emergency assistance with various needs such as: rent, utilities, car repair, and quality of life issues. Over one half of the requests funded in recent years were first time applicants. The requests are comprised of referrals from member organizations and industry.

"Dads in Action"

Dads in Action is a new program launched in the fall of 2003 that is designed to encourage dads to take a more active role in their children's lives, to be more involved in the care of their child with hemophilia and to strengthen communication throughout the family. Participants return to their home chapters to start a "Dads in Action" program where they carry the lessons learned to fellow Dads at their local chapter. The program receives high reviews from participants and is an integral part of our vision for the community.

The Annual HFA Symposium

HFA's annual Symposium is one of the brightest stars in our programmatic agenda. This event has grown from a small gathering of 100 people in 1996 to over 500 in 2006. Are sole focus at this annual event is the consumer. Our patients view that annual symposium as a big family reunion where they learn how to cope with everyday situations. There are also free programs for teens and children. The goal of the Symposium is to address issues that impact the entire community. Presenters are experts in their field and share their expertise with the community.

FISCAL YEAR 2007 APPROPRIATIONS RECOMMENDATIONS

Hemophilia Treatment Centers/Health Resources and Services Administration

In 1974, Congress created a network of Hemophilia Treatment Centers (HTCs) throughout the United States. This treatment centers remain essential to ensuring that comprehensive and specialized care is available for persons with bleeding disorders. There are currently over 140 HTCs in the United States. These centers abide by Federal guidelines for the delivery of comprehensive hemophilia services as developed by the Health Resources and Services Administration and the Centers for Disease Control and Prevention.

HTC's provide family centered, state-of-the-art medical and psychosocial services, as well as education and research to persons with inherited bleeding disorders. The bleeding disorder community utilizes many services through the Hemophilia Treatment Centers. These services include diagnostic evaluations for hemophilia, von Willebrand disease and other bleeding disorders. They also include annual comprehensive evaluations, clinical trials on new blood clotting therapies, coordination with the individual's primary care physician, emergency consultations, hematological management for surgeries, dental procedures and childbirth. HTC's educate patients and family members on infusion training, encourage collaboration

with clinicians throughout the United States, participate in CDC research, and collaborate with the hemophilia community.

At the Health Resources and Services Administration, funding is provided to HTC's through the Maternal and Child Health Block Grant program. For fiscal year 2007, HFA encourages the subcommittee to reject the president's proposed $36 million cut to MCHBG, and restore funding to the fiscal year 2006 level of $816 million.

Hemophilia Program at the Centers for Disease Control and Prevention

Mr. Chairman, HFA strongly supports the expansion of hemophilia related programs within CDC's National Center on Birth Defects and Developmental Disabilities' Hereditary Blood Disorders program. In partnership with HRSA, this program provides vital support to Hemophilia Treatment Centers, particularly in the areas of research, education, disease management, blood safety and surveillance. For fiscal year 2007, HFA encourages the subcommittee to provide an increase of $3 million for hemophilia related activities at CDC. This proposed increase would bring the total level of CDC funding for the hemophilia treatment center network to $10 million. This increase is important given the fact the program has been level funded for over 10 years.

HFA was very pleased that the fiscal year 2006 Senate Labor-HHS–Education committee report encouraged CDC to expand opportunities for additional patient-based organizations to participate in the agency's hemophilia program. Under the current structure of the program, only one hemophilia organization is eligible to receive support for the purpose of providing much needed services to patients. In order to maximize the effectiveness of the CDC program, we believe that additional patient based organizations should be empowered to receive funding on an annual basis. As referenced earlier, HFA offers a wide variety of high quality, consumer focused, programs that no other organization provides. If the CDC program were opened-up to allow additional organizations to participate, we would be able to help a much larger number of patients and families throughout the country. We encourage the subcommittee to support our efforts in this regard in the fiscal year 2007 bill.

Research at the National Institutes of Health

HFA applauds the National Heart, Lung and Blood Institute, the National Institute of Diabetes and Digestive and Kidney Diseases, and the National Institute of Allergy and Infectious Diseases for their strong support of hemophilia related research. We are grateful to the subcommittee for recognizing the growing problem of bleeding disorders in women, which if untreated, can lead to serious medical conditions including anemia, unnecessary hysterectomies, and menstrual complications.

Patients and families in the hemophilia community are placing their hopes for a better quality of life on treatment advances made through biomedical research. For fiscal year 2007, we encourage the subcommittee to provide a 5 percent increase overall for each institute and center at the NIH.

Mr. Chairman, thank you for the opportunity to present the views of the Hemophilia Federation of America.

PREPARED STATEMENT OF HEPATITIS FOUNDATION INTERNATIONAL

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS

—Continue the great strides in research at the National Institutes of Health (NIH) by providing a 5 percent budget increase for fiscal year 2007. Increase funding for the National Institute for Allergy and Infectious Diseases (NIAID), the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute on Drug Abuse (NIDA) by 5 percent.

—Continued support for the hepatitis B vaccination program for adults at the Centers for Disease Control and Prevention (CDC) as well as CDC's Prevention Research Centers by providing an 8 percent increase for CDC.

—Support for the Substance Abuse and Mental Health Services Administration (SAMHSA) by providing an 8 percent increase in fiscal year 2007.

—Urge CDC, NIAID, NIDDK, NIAAA, NIDA, and SAMHSA to work with voluntary health organizations to promote liver wellness, education, and prevention of both hepatitis and substance abuse.

Mr. Chairman and members of the subcommittee, thank you for your continued leadership in promoting better research, prevention, education, and control of diseases affecting the health of our Nation. I am Thelma King Thiel, Chairman and Chief Executive Officer of the Hepatitis Foundation International (HFI).

Currently, five types of viral hepatitis have been identified, ranging from type A to type E. All of these viruses cause acute, or short-term, viral hepatitis. Hepatitis B, C, and D viruses can also cause chronic hepatitis, in which the infection is prolonged, sometimes lifelong. While treatment options are available for many patients, individuals with chronic viral hepatitis B and C represent a significant number of patients requiring a liver transplant. Current treatments have limited success and there is no vaccine available for hepatitis C, the most prevalent of these diseases.

HEPATITIS A

The hepatitis A virus (HAV) is contracted through fecal/oral contact (i.e. fecal contamination of food, water, and diaper changing tables if not cleaned properly), and sexual contact. In addition, eating raw or partially cooked shellfish contaminated with HAV can spread the virus. Children with HAV usually have no symptoms; however, adults may become quite ill suddenly experiencing jaundice, fatigue, nausea, vomiting, abdominal pain, dark urine/light stool, and fever. There is no treatment for HAV; however, recovery occurs spontaneously over a 3 to 6 month period. About 1 in 1,000 with HAV suffer from a sudden and severe infection that may require a liver transplant. A highly effective vaccine can prevent HAV. This vaccination is recommended for all children and individuals who have chronic liver disease or clotting factor disorders, in addition to those who travel or work in developing countries.

HEPATITIS B

Hepatitis B (HBV) claims an estimated 5,000 lives every year in the United States, even though therapies exist that slow the progression of liver damage. Vaccines are available to prevent hepatitis B. This disease is spread through contact with the blood and body fluids of an infected individual and from an HBV infected mother to child at birth. Unfortunately, due to both a lack in funding to vaccinate adults and the absence of an integrated preventive education strategy, transmission of hepatitis B continues to be problematic. Additionally, there are significant disparities in the occurrence of chronic HBV-infections. Asian Americans represent four percent of the population; however, they account for over half of the 1.3 million chronic hepatitis B cases in the United States. Current treatments do not cure hepatitis B, but appropriate treatment can help to reduce the progression to liver cancer and liver failure. Yet, many are not treated. Preventive education and universal vaccination are the best defenses against hepatitis B.

HEPATITIS C

Infection rates for hepatitis C (HCV) are at epidemic proportions. Unfortunately, many individuals are not aware of their infection until many years after they are infected. This creates a vicious cycle, as individuals who are infected continue to spread the disease, unknowingly. The Center for Disease Control and Prevention estimates that there are over 4 million Americans who have been infected with hepatitis C, of which over 2.7 million remain chronically infected, with 8,000–10,000 deaths each year. Additionally, the death rate is expected to triple by 2010 unless additional steps are taken to improve outreach and education on the prevention of hepatitis C and scientists identify more effective treatments and cures. As there is no vaccine for HCV, prevention education and treatment of those who are infected serve as the most effective approach in halting the spread of this disease.

PREVENTION IS THE KEY

The absence of information about the liver and hepatitis in education programs over the years has been a major factor in the spread of viral hepatitis through unknowing participation in liver damaging activities. Adults and children need to understand the importance of the liver and how viruses and drugs can damage its ability to keep them alive and healthy. Many who are currently infected are unaware of the risks they are taking that expose them to viral infections and ultimate liver damage.

Knowledge is the key to prevention. Preventive education is essential to motivate individuals to protect themselves and avoid behaviors that can cause life-threatening diseases. Primary prevention that encourages individuals to adopt healthful lifestyle behaviors must begin in elementary schools when children are receptive to learning about their bodies. Schools provide access to one-fifth of the American population.

Individuals need to be motivated to assess their own risk behaviors, to seek testing, to accept vaccination, to avoid spreading their disease to others, and to under-

stand the importance of participating in their own health care and disease management. The NIH needs to support education programs to train teachers and healthcare providers in effective communication techniques, and to evaluate the impact preventive education has on reducing the incidence of hepatitis and substance abuse.

Therefore, HFI recommends that CDC, NIAID, NIDDK, NIAAA, NIDA, and SAMHSA be urged to work with voluntary health organizations to promote liver wellness, education, and prevention of viral hepatitis, sexually transmitted diseases and substance abuse.

Only a major investment in immunization and preventive education will bring these diseases under control. All newborns, young children, young adults, and especially those who participate in high-risk behaviors must be a priority for immunization, outreach initiatives, and preventive education. We recommend that the following activities be undertaken to prevent the further spread of all types of hepatitis:

—Provide effective preventive education in our elementary and secondary schools so children can avoid the serious health consequences of risky behaviors that can lead to viral hepatitis.

—Train educators, health care professionals, and substance abuse counselors in effective communication and counseling techniques.

—Promote public awareness campaigns to alert individuals to assess their own risk behaviors, motivate them to seek medical advice, encourage immunization against hepatitis A and B, and to stop the consumption of any alcohol if they have participated in risky behaviors that may have exposed them to hepatitis C.

—Expand screening, referral services, medical management, counseling, and prevention education for individuals who have HCV, many of whom may be co-infected with HIV and Hepatitis C and/or Hepatitis B.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

HFI recommends an 8 percent increase in fiscal year 2007 for further implementation of CDC's Hepatitis C Prevention Strategy. This increase will support and expand the development of State-based prevention programs by increasing the number of State health departments with CDC funded hepatitis coordinators. The Strategy will use the most cost-effective way to implement demonstration projects evaluating how to integrate hepatitis C and hepatitis B prevention efforts into existing public health programs.

CDC's Prevention Research Centers, an extramural research program, plays a critical role in reducing the human and economic costs of disease. Currently, CDC funds 26 prevention research centers at schools of public health and schools of medicine across the country. HFI encourages the subcommittee to increase core funding for these prevention centers, as it has been decreasing since this program was first funded in 1986. We recommend the subcommittee provide an 8 percent increase for the Prevention Research Centers program in fiscal year 2007.

Also, HFI recommends that the CDC, particularly the Division of Adolescent and School Health (DASH), work with voluntary health organizations to promote liver wellness with increased attention toward childhood education and prevention.

INVESTMENTS IN RESEARCH

Investment in the NIH has led to an explosion of knowledge that has advanced understanding of the biological basis of disease and development of strategies for disease prevention, diagnosis, treatment, and cures. Countless medical advances have directly benefited the lives of all Americans. NIH-supported scientists remain our best hope for sustaining momentum in pursuit of scientific opportunities and new health challenges. For example, research into why some HCV infected individuals resolve their infection spontaneously may prove to be life saving information for others currently infected. Other areas that need to be addressed are:

—Reasons why African Americans do not respond as well as Caucasians and Hispanics to antiviral agents in the treatment of chronic hepatitis C.

—Pediatric liver diseases, including viral hepatitis.

—The outcomes and treatment of renal dialysis patients who are infected with HCV and HBV.

—Co-infections of HIV/HCV and HIV/HBV positive patients.

—Hemophilia patients who are co-infected with HIV/HCV and HIV/HBV.

—The development of effective treatment programs to prevent recurrence of HCV infection following liver transplantation.

—The development of effective vaccines to prevent HCV infection.

HFI supports a 5 percent increase for NIH in fiscal year 2007. HFI also recommends a comparable increase of 5 percent in hepatitis research funding at NIAID, NIDDK, NIAAA, and NIDA.

HFI is dedicated to the eradication of viral hepatitis, which affects over 500 million people around the world. We seek to raise awareness of this enormous worldwide problem and to motivate people to support this important—and winnable—battle. Thank you for providing this opportunity to present testimony.

PREPARED STATEMENT OF IN DEFENSE OF ANIMALS

Six years ago, In Defense of Animals (IDA) testified before Congress about the NIH's egregious oversight failures and illegal funding of the New Mexico-based Coulston Foundation, at the time the world's largest chimpanzee lab. IDA testified about Coulston's abysmal animal care record and unprecedented violations, dating back to 1993, of Federal animal welfare laws. IDA recommended, among other things, a Congressional investigation.

Within weeks of IDA's March 2000 testimony, the NIH took ownership of 288 chimpanzees from Coulston, citing concerns about the lab's resources and ability to properly care for the animals, which IDA had raised in our testimony. The NIH left the chimpanzees in Coulston's "care" and continued to illegally fund the lab despite its continued animal welfare violations.

The NIH's Coulston oversight debacle resulted in international media coverage, public outrage and intense Congressional scrutiny. As a result, the NIH was finally forced to end its illegal funding of Coulston in June 2001. The agency took over ownership of the lab where the 288 chimpanzees were housed, renamed it the "Alamogordo Primate Facility" (APF), and awarded a ten-year, $42 million taxpayer-funded contract to Charles River Laboratories (CRL) to operate it. However, the APF was now NIH-owned and part of the agency's Intramural Research Program; the contract between the NIH and CRL explicitly states that the NIH is responsible for "day-to-day management" of the lab, including its "associated animal activities."

Subsequently, the House Committee on Energy and Commerce conducted an investigation, and found that the NIH had indeed continued to fund Coulston despite its violation of Federal administrative laws. This prompted the Investigations subcommittee to question the NIH's oversight and management of billions of dollars in taxpayer-funded grants; this subcommittee consequently launched a broad investigation of the NIH in March 2003.

Amazingly, six years after IDA's March 2000 testimony, the NIH oversight debacle that launched a prior Congressional investigation is actually worse, and cries out for Congressional action. That is because in September 2004, New Mexico District Attorney Scot Key filed multiple counts of criminal animal cruelty against CRL. After an independent investigation that lasted almost one year, the D.A. found that it was "standard practice" for CRL to have trained animal care staff leave at the end of the workday, and leave the "care" of critically ill or injured chimpanzees to once-per-hour monitoring by untrained security guards. This "standard practice"—instituted in August 2002 as an apparent cost-saving measure—resulted in the suffering and deaths of two chimpanzees, Rex and Ashley, and the near-death of a third, Topsy. The D.A. charged CRL and APF Director Rick Lee with three counts of criminal cruelty alleging abandonment and failure to provide necessary sustenance. This understaffed small-town D.A. with a caseload of murders had stepped in to enforce the law and protect the chimpanzees from a multi-billion dollar public company and a $28 billion Federal agency. It should be noted that because the APF is now a Federal research lab, the USDA has no jurisdiction under the Animal Welfare Act. This was the first time in U.S. history that an entire lab had been charged with criminal animal cruelty. This case, the culmination of 10 years of NIH-funded abuse of these New Mexico chimpanzees, contains shocking facts that cry out for further Congressional action.

Despite initial promises of cooperation, CRL instead hired a high-powered criminal law firm perhaps best known for obtaining an acquittal of a two-time husband killer after she had shot husband number two in New Mexico. CRL refused to cooperate with the D.A.'s criminal investigation. CRL refused to comply with the D.A.'s subpoena demanding records relating to the three chimpanzees. The D.A. then obtained a grand jury subpoena, but CRL still refused to supply the records to the D.A. The NIH did nothing to force CRL to cooperate.

Tellingly, however, CRL did supply these records to an ad-hoc NIH consultant with no law enforcement authority. During only a portion of his one-day site visit, this veterinarian simply reviewed the records, without interviewing a single witness, and, predictably, found no problems. Neither the NIH nor CRL wanted an

independent, legitimate law enforcement officer, such as the D.A., to get within a mile of these records, and did everything possible to prevent his obtaining them. The NIH did not want any independent, legitimate investigation, since any problems found would be an indictment of the agency's own management of the lab. The NIH's responsibility for "oversight" at its own lab constitutes an unmitigated conflict of interest. Had the NIH found a chimpanzee shot in the head, the agency would no doubt have ruled it a suicide.

Like CRL, the NIH has also refused to supply these records to the public, even after IDA filed a Federal FOIA lawsuit in September 2004. In its briefs, the NIH has actually claimed that it does not possess these clinical records—for NIH-owned chimpanzees at an NIH-owned facility that is part of the NIH's Intramural Research Program. This laughable assertion is belied by the NIH's own contract with CRL, which explicitly states that the NIH does indeed possess these records.

CRL submitted only one of two reports generated by the one-day NIH site visit to the New Mexico court trying the criminal case—predictably, the one praising CRL's veterinary care, which was based on only a review of records, not any witness interviews nor an actual investigation. However, the criminal charges had nothing to do with CRL's veterinary care, but instead CRL's alleged "standard practice" of abandoning critically ill or injured chimpanzees to once-per-hour monitoring by untrained security guards. The second report, written by the NIH Project Officer for the CRL contract and obtained by IDA through FOIA, clearly shows that the NIH was completely and totally unaware of the abandonment alleged by the D.A.

During the time period covered by the multiple counts of criminal animal cruelty, the NIH actually awarded CRL bonuses totalling $175,000 paid for with taxpayer funds. CRL received the maximum bonuses; the major criterion for these bonuses was "no animal care deficiencies."

While the D.A.'s independent investigation—run by a 24-year police veteran—took almost a year and interviewed six witnesses, including eyewitnesses, the NIH interviewed no witnesses regarding Rex, Ashley and Topsy and allowed the so-called "investigation" to be conducted by CRL—another blatant conflict of interest. Because CRL refused to cooperate—despite its initial promises—the D.A. could only interview ex-CRL employees. But those ex-employees painted a devastating portrait of the alleged acts of cruelty and CRL's operation of this NIH lab.

Dr. Kelly Avila started work at the APF only 58 days after she graduated from veterinary school. She told the D.A.'s investigator that she had been promised training, but instead found herself the main clinician for over 250 chimpanzees. She confirmed that in August 2002, APF Director Rick Lee instituted the policy where security guards would take over for animal care at quitting time, 4:00 p.m. She repeatedly stated that Ashley, the first chimpanzee mentioned in the criminal charges, had shock. Avila had "serious problems" with APF practices, and discussed problems associated with having security/maintenance personnel perform animal care. She started a system of writing daily reports of what she found on exams and also which chimpanzees were sick and needed monitoring; apparently no such systemic surveillance existed before her arrival. Being fresh out of vet school, she also said she felt she had to defer to the more-experienced vets Lee and Langner. She stated that financial considerations played a role in the standard of care; if she wanted an animal care staffer to stay past quitting time she would have to go through Andrea Lee, the APF's Program Administrator and wife of Director Rick Lee. That would have "meant that Dr. Lee's wife would have gotten all over my case for overtime." Avila said that it was "always a fight" with Andrea Lee—who had no veterinary training whatsoever—and that the "veterinary staff . . . either cowed down to this lady or you had to leave." Avila also stated that Rick Lee, instead of training her as promised, "spent his time in the office doing director kind of activities," and that she hardly ever saw him. Instead, she said her mentors included an online message board, the Veterinary Information Network (VIN).

Dr. Avila posted dozens of messages to the VIN during her year working at the APF. Perhaps the most devastating was posted on September 16, 2002, only hours before Ashley died. Avila explains Ashley's condition, that she was bleeding from a fight and suffered from a condition that makes blood clotting more difficult. After describing how she had treated Ashley to that point, she then asks the chilling, all-revealing question: "Does anyone have other ideas on how to treat?" Many of these messages demonstrate a facility in disarray, and a veterinarian fresh out of vet school who was trying to do the right thing but was clearly in over her head. Avila asked for advice on almost every conceivable subject relating to chimpanzee care: reference texts for chimpanzee nutrition (she noticed what she thought were signs of malnutrition); how to conduct biopsies and take bone marrow samples; how to treat hypertension; how to interpret ultrasounds and x-rays. She repeatedly stated that she conducted her own medical literature searches in attempts to find treat-

ments. She tells of her APF colleagues' ignorance of specific treatments and dangerous side effects of drugs. In a May 23, 2003 post, she states "I recently lost my fifth chimp," then describes how a chimp died after a tooth extraction. Importantly, she states that this chimp had a history of suffering from grand mal seizures when given ketamine, which is one of the only two sedatives allowed at the APF (the other is pharmacologically similar to ketamine), and says that she had just been lucky prior to that because she had given him only very small doses as supplements. She states this is one of the reasons she is resigning. She tells VIN that respiratory diseases, measles and chicken pox have been passed to the chimps from human employees over the past year. She asks about vaccinations, questioning why the APF only vaccinates against tetanus, and is told that there is a standard series of vaccinations recommended for chimpanzees, which includes tetanus, measles, mumps and rubella. She describes her fight against a drug company trying to test a drug for hepatitis C on chimpanzees, since the side effects in humans are so severe and she is concerned that the chimpanzees would suffer, while relating that she "dislike[s] the pressure greatly" that she is getting from the drug company to perform the study. For one chimpanzee, she is "at her wits end" in trying to find a treatment; one she had previously used "led to more edema so I won't be doing that again. Oh well I guess I am learning here," and then asks for suggestions on how to treat. She asks if anyone knows of a procedure for tapping the heart (fluid) of a chimpanzee, and asks "Do I proceed as I would with a dog?" In another revealing post, she asks if anyone has experience with using steroids as an appetite stimulant in chimpanzees, for a 40-year-old. Other vets chime in, saying that old age is not a disease, and that this and some of her other posts indicate that she is treating symptoms, not trying to get diagnosis so she can treat an underlying disease. Avila responds with a devastating indictment of the APF operation: "I am working at getting actual diagnosis before I continue treatments. There is great resistance to this as the old adage 'if it ain't broke don't fix it' applies here on a regular basis! However, it is against my nature to give up and allow people to act foolishly while I clean up the mess they leave behind so I will continue to try to find specific diagnosis and treat those whenever I can." A similar post concerns a self-mutilating chimpanzee; Avila is concerned about the long-term effects of Prozac. Vets chime in again that she should try to determine the underlying cause of the self-mutilation; one vet relates that's what she did, and was able to stop the mutilation and wean a baboon off of Prozac. Avila states that the APF behaviorist pretty much wants to keep the chimpanzee on Prozac forever, and agrees that she should try to find the underlying cause of the self-mutilation.

Maintenance man Ernest Farwell went into great detail about the cases of Rex and Ashley to the D.A.'s investigator. He confirms Dr. Avila's recollection that August 2002 is when CRL instituted the policy of having maintenance/security, such as Farwell, take over from animal care after quitting time. Like the other maintenance man interviewed, Benjamin Thompson, Farwell confirmed that he received no special training in chimpanzee care. He saw Rex unconscious, lying on his side with his mouth open, vomiting, and an animal care staffer suctioning out the vomit with an evacuation wand. He witnessed Dr. Avila say to the animal care staffer "We have to go, he won't let us stay." The animal care staffer then actually removed Rex's life support, and he and Avila left while Rex was still unconscious and vomiting. Farwell later witnessed Rex on his side, but with the vomit coming out of his mouth (since no one was there to suction it out). Rex was found dead later that night; the pathology report showed vomit in his mouth and trachea. Farwell also witnessed Ashley; when he first saw her, he was shocked at the amount of blood in her cage, and she was still bleeding. He then witnessed her shake violently; this was the symptom of shock mentioned by Dr. Avila in her witness statement. Later he found her dead. Farwell also states that APF employees were threatened with polygraph tests when Rick Lee was trying to find out who gave information to the D.A. about the alleged cruelty, and were ordered not to speak with anyone, including the D.A., about the allegations. Such threats violate the 1988 Federal Employee Polygraph Protection Act. This climate of intimidation was also apparent when Farwell complained about having to give medicine to chimpanzees, protesting that he wasn't qualified, explaining "If animal care found a problem with the boilers you wouldn't expect them to fix it." He was then written up and felt threatened, and signed an agreement that he would perform these duties (i.e., care of chimpanzees) and anything else CRL told him to, for apparent fear of losing his job.

The APF had problems from day one; for the first 6 months, the facility did not have requirements for care as basic as euthanasia drugs. This resulted in chimpanzee suffering; CRL actually had to borrow euthanasia drugs from the Coulston Foundation, which was offsite, miles away, and almost bankrupt. Although the chimpanzees lacked for drugs, APF Program Administrator Andrea Lee—who made

decisions on animal care overtime—had plenty; in 2004, she was criminally charged with 15 counts of fraudulently obtaining a controlled substance (Vicodin). She had been illegally using the DEA licenses of two APF veterinarians—at a taxpayer-funded facility—and pled guilty to one count. APF veterinarian Cynthia Doane—not the NIH or CRL management—became suspicious and began to investigate. Further buttressing the existence of a climate of intimidation and fear at the APF, Doane wrote a letter to the New Mexico Board of Pharmacy in April 2004, stating her willingness to help in the investigation, but that "I emphasize, however, that I cannot trust anyone at my place of work at this time."

Instead of proclaiming its innocence by demanding its day in court, CRL, presumably with the NIH's blessing, threw up one legal technicality after another in a prolonged effort to hide from the evidence accumulated by the D.A. and to prevent a jury, and the public, from ever seeing it argued in open court. CRL claimed that the State of New Mexico had no jurisdiction to prosecute its own animal cruelty statute because the APF was located on a Federal Air Force Base, despite the fact that the New Mexico legislature had specifically amended its cruelty statute in 2001 because of the chimpanzee abuses at this very same facility. This amendment gave the D.A. the legal authority to prosecute CRL. The company claimed that because the New Mexico cruelty statute did not require qualified personnel, there was no abandonment because untrained security guards were in the vicinity of the critically ill or injured chimpanzees (once per hour). And in the most egregious of all the technicalities, CRL actually claimed that it was engaged in the practice of veterinary medicine in the cases of Rex, Ashley and Topsy, and because the cruelty statute exempts the practice of veterinary medicine, the case should be dismissed. In other words, according to CRL and the NIH, the deliberate policy of denying veterinary care constitutes the practice of veterinary care. Incredibly, the judge agreed with that technicality, and dismissed the case—a dismissal having nothing to do with the merits of the D.A.'s investigation or case. The D.A. appealed, and the case is currently being adjudicated at the New Mexico Court of Appeals, the State's second-highest court.

RECOMMENDATIONS

IDA believes that given the NIH's egregious record, Congress should both investigate and hold hearings, not only into the NIH/Coulston/Charles River debacle, but the larger oversight issues raised by the NIH's actions. One would have thought that, given the years of Coulston Foundation administrative animal welfare violations, the NIH would have been that much more careful in choosing and overseeing a successor. Instead, the facility—now directly owned and managed by the NIH—descended into alleged criminal animal cruelty. Given the NIH's ten-year record of funding abuse against these chimpanzees, we respectfully request that the NIH be barred from any responsibility whatsoever for them. These chimpanzees have endured enough; the survivors should be placed at a reputable private sanctuary for permanent retirement, with the remainder of the $42 million contract going to the sanctuary. This would be the morally and ethically correct course of action that is so greatly overdue for these long-suffering chimpanzees.

PREPARED STATEMENT OF INDEPENDENCE TECHNOLOGY

Mr. Chairman and members of the subcommittee, my name is Gregg Howard and I am the Vice President for Sales and Reimbursement for Independence Technology, LLC, a Johnson & Johnson company. I appreciate the opportunity to provide comments in support of the many programs within the jurisdiction of the subcommittee that are important to citizens with disabilities.

The Institute of Medicine report, "Disability in America: Toward a National Agenda," began with the words "Disability is an issue that affects every individual, community, neighborhood, and family in the United States." These words are as true today as when the IOM published its report.

The demographic imperative resulting from the aging of the baby boom generation will soon substantially increase the proportion and numbers of Americans in the older age groups that are most at risk of physical and mental impairments, limitations, and disabilities. At the same time, certain trends in other age groups—for example, the increased rates of survival of extremely premature infants, increases in the prevalence of obesity in younger populations and a growing number of disabled Iraq era veterans—are putting more children and younger adults at risk of disabling conditions. Thus, the promotion of good health, independence, and social integration for people with disabilities and the prevention of disabling injuries, diseases, and disorders are more important objectives than ever.

Mr. Chairman, the Labor, Health and Human Services, and Education subcommittee funds the significant majority of Federal programs of interest and benefit to citizens with disabilities. These programs are in the Department of Labor, the Department of Health and Human Services, and the Department of Education. At the end of this statement, we list these many programs in tabular form and include a fiscal year 2007 funding recommendation for each of these programs. We join with the 100 plus organizations of Consortium for Citizens with Disabilities in making these recommendations and would urge the subcommittee's efforts to address these funding needs.

Mr. Chairman, also very importantly, the Social Security Administration, Medicare and Medicaid programs are of significant importance for citizens with disabilities. While these programs are mostly viewed as entitlements and therefore fall in the jurisdiction of the Senate Finance Committee and House Ways and Means Committee, your subcommittee appropriates administrative funds that permit the operations of these programs. On behalf of Independence Technology, LLC, I would like to highlight a matter currently under consideration by administrative personnel at Medicare that will have an important impact on the lives of many disabled Americans.

Independence Technology, LLC, has invested over $100 million over the last decade to develop a revolutionary new mobility system that allows individuals with disabilities to achieve extensive function and the physical mobility necessary in order to live independently. This innovative technology is the first of its kind to largely eliminate barriers by climbing stairs, improving reach, transversing various surfaces, and balancing the seated user at standing eye level. For many this technology can take the place of more costly and/or drastic alternatives such as moving from one's home, extensive home modifications, use of home health aides, and unnecessary institutionalization or bed confinement.

While this new technology is clearly not appropriate for all individuals with mobility impairments, for the subset disabled of individuals for whom it is appropriate, it is a life changing device which improves health, functional status, independent living, and quality of life. In 2002 and 2003 the Veterans Health Administration evaluated these devices and made a determination as to which subset of disabled veterans could appropriately benefit from the device. Based on this review and policy determination, the Veterans Health Administration now prescribes and provides financial support for the procurement of these devices.

Currently underway at CMS is a similar review process. On January 26, 2006 CMS posted for public comment the application by Independence Technology, LLC, for the development of a National Coverage Determination for an interactive balancing mobility system such as the iBOT. A total of 151 comments were presented to CMS by patients, disability groups, health care providers, and others affected by disabilities. Letters were also sent in support of the application by 10 U.S. Senators and approximately 20 House Members. Overall, 97 percent of the comments provided to CMS on this matter were positive.

The comment period for establishing a National Coverage Determination for "interactive balancing mobility systems" closed on March 5, 2006. CMS now has up to 6 months to announce a decision on the question of proceeding to the development of a National Coverage Determination. It is our view that the establishment of coverage criteria for this new state-of-the-art interactive balancing mobility systems sends an important message that when research and development results in technological advancements improving the health, functional status, independent living, and quality of life, these advances will be made accessible to those who will benefit.

Mr. Chairman, in summary we appreciate the leadership of you and your subcommittee in championing so many important programs of benefit to disabled Americans. While we recognize the limitations placed on the subcommittee by spending ceilings, we would urge your careful review and considerations of the funding recommendations found at the end of this statement. We would also request the subcommittee's support and direct guidance to CMS to support reimbursement policies that will help bring new technological advances such as the iBOT to disabled Americans who stand to benefit from their use.

Thank you for the opportunity to testify.

APPROPRIATIONS RECOMMENDATIONS FOR FISCAL YEAR 2007

[In millions of dollars]

	Fiscal year 2006 final	Fiscal year 2007 President	Fiscal year 2007 CCD
DEPARTMENT OF LABOR			
Workforce Investment Act (selected programs):			
Adult Employment	857.0	712.0	987.9
Pilots, Demonstrations, Research	29.7	17.7	151.0
Youth Activities	940.5	840.5	1,093.4
Office of Disability Employment Policy	27.7	20.0	47.5
Work Incentives Grants	19.5	.....	20.7
DEPARTMENT OF HEALTH AND HUMAN SERVICES			
Health Services Resources Administration:			
Maternal & Child Health Block Grant	693.0	693.0	724.0
Developmental Disabilities Act Programs:			
Basic State Grants—Councils on DD	71.8	72.0	84.5
Protection & Advocacy Systems—DD	38.7	39.0	45.0
University Centers for Excellence in DD	33.2	33.0	37.0
Projects of Nat'l Sig. & Family Support	11.4	11.0	22.6
TBI State Grants	9.0	.....	15.0
TBI Protection & Advocacy Grants	3.1	.....	6.0
Universal Newborn Hearing Screening	10.0	.....	10.0
Centers for Disease Control and Prevention:			
Birth Defects, Developmental Disabilities, & Health	124.7	110.5	137.6
Chronic Disease Prevention	836.6	818.7	417.4
Environmental Health	149.9	141.0	153.0
Preventive Health Block Grant	99.0	.....	133.6
Injury Prevention and Control	139.0	138.2	142.8
Epilepsy Program	7.7	.....	8.0
TBI Registries and Surveillance	5.3	5.3	9.0
National Institutes of Health	28,578.0	28,578.0	29,750.0
Natl. Institute of Child Health and Hum. Dev.	1,264.7	1,257.0	1,327.9
Natl. Institute on Deafness & Other Communication Disorders	393.0	392.0	412.7
Natl. Inst. of Neurological Disorders & Stroke	1,534.8	1,525.0	1,611.5
Natl. Institute on Mental Health	1,403.8	1,395.0	1,474.0
Natl. Institute on Drug Abuse	1,000.0	995.0	1,050.0
Natl. Institute on Alcohol Abuse	435.9	433.0	457.7
Social Services Block Grant	1,683.0	1,200.4	2,380.0
Child Care & Development Block Grant	2,062.1	2,062.0	2,588.0
Head Start	6,876.0	6,786.0	7,300.0
Child Abuse Prevention and Treatment Act	95.2	101.0	142.0
Nat'l Family Caregiver Support Program	162.0	160.0	162.0
Grants to States to Remove Barriers to Voting	10.9	10.9	25.0
Protection & Advocacy for Voting Access	4.9	4.8	10.0
SAMHSA:			
Children's Mental Health Services	104.1	104.1	109.7
PATH Homeless Program	54.3	54.3	57.1
Protection & Advocacy for Indivs. with MI	34.0	34.0	40.0
Mental Health Block Grant	428.5	428.5	451.2
Projects of Regional and Nat'l Significance	263.2	228.1	285.9
DEPARTMENT OF EDUCATION			
Individuals with Disabilities Education Act:			
State and Local Grants Part B	10,582.8	10,682.9	16,938.9
Preschool Grants	380.8	380.8	841.0
Early Intervention Part C	436.4	436.4	680.0
Part D National Programs:			
State Personnel Development	50.1	.....	55.7
Technical Assistance and Dissemination	48.9	48.9	57.6
Personnel Preparation	89.7	89.7	108.7
Parent Information Centers	25.7	25.7	28.6
Technology and Media	38.4	31.1	42.6
Transition Initiative	.....	2.0	5.5
Research and Innovation (Inst. Ed. Sciences)	81.7	81.7	92.4

APPROPRIATIONS RECOMMENDATIONS FOR FISCAL YEAR 2007—Continued

[In millions of dollars]

	Fiscal year 2006 final	Fiscal year 2007 President	Fiscal year 2007 CCD
Rehabilitation Services Administration:			
Rehabilitation State Grant	2,693.0	2,837.2	3,120.0
Client Assistance Programs	11.8	11.8	13.0
Rehabilitation Training	38.4	38.4	42.7
Special Demonstrations	6.5	6.5	28.1
Recreation	3.0	.....	3.0
Protection & Advocacy for Individual Rights	16.5	16.5	22.0
Projects with Industry	20.0	.....	50.0
Supported Employment State Grant	29.7	.....	50.0
Migrant & Seasonal Farm workers	2.0	.....	2.3
Independent Living State Grant	22.6	22.6	25.0
Centers for Independent Living	74.6	74.6	82.9
Independent Living Serv. for Older Blind Ind.	32.9	32.9	36.5
State Assistive Technology Programs and TA	22.4	22.4	29.0
Protection & Advocacy for Assistive Tech.	4.4	.....	6.0
National Institute for Disability & Rehabilitation Research	106.7	106.7	120.0
Demonstration Projects-Disability (Higher Ed.)	6.9	.....	10.0
National Council on Disability	3.1	2.8	3.7
Helen Keller National Center	8.5	8.5	11.7
American Printing House for the Blind	17.6	17.6	20.0

PREPARED STATEMENT OF THE INTERNATIONAL FOUNDATION FOR FUNCTIONAL GASTROINTESTINAL DISORDERS

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS

—Provide a 5 percent increase for fiscal year 2007 to the National Institutes of Health (NIH) budget. Within NIH, provide proportional increases of 5 percent to the various institutes and centers, specifically, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

—Accelerate funding for extramural clinical and basic functional gastrointestinal disorders (FGID) and motility disorders research at NIDDK.

—Continue to urge NIDDK to develop a strategic plan on irritable bowel syndrome (IBS) with the purpose of setting research goals, determining improved treatment options for IBS sufferers, and assisting in recruitment of new investigators to conduct IBS research.

—Urge the National Institute of Child Health and Human Development (NICHD) and NIDDK to continue to support research into fecal and urinary incontinence, including the development of a standardization of scales to measure incontinence severity and quality of life and to develop strategies for primary prevention of fecal incontinence associated with childbirth.

—Provide funding to NIDDK and the National Cancer Institute (NCI) for more research on the causes of esophageal cancer.

Chairman Specter and members of the subcommittee, thank you for the opportunity to present this written statement regarding the importance of functional gastrointestinal and motility disorders research. IFFGD has been serving the digestive disease community for fifteen years. We work to broaden the understanding about functional gastrointestinal and motility disorders in adults and children. IFFGD speaks about and raises awareness on disorders and diseases that many people are uncomfortable and embarrassed to talk about. The prevalence of fecal incontinence and irritable bowel syndrome or IBS, as well as a host of other gastrointestinal disorders affecting both adults and children, is underestimated in the United States. These conditions are truly hidden in our society. Not only are they misunderstood, but also the burden of illness and human toll has not been fully recognized.

Since its establishment, the IFFGD has been dedicated to increasing awareness of functional gastrointestinal and motility disorders, among the public, health professionals, and researchers. While maintaining a high level of public education efforts, the IFFGD has also become recognized for our professional symposia. We consistently bring together a unique group of international multidisciplinary investigators to communicate new knowledge in the field of gastroenterology. In the spring

of 2007, IFFGD will be hosting our Seventh International Symposium on Functional Gastrointestinal Disorders, bringing scientists, researchers, and clinicians from across the world together to discuss the current science and opportunities on IBS and other functional gastrointestinal and motility disorders. Also, in November of 2002, we hosted a conference on fecal and urinary incontinence, the proceedings of which were published in Gastroenterology, the official journal of the American Gastroenterological Association (AGA). The IFFGD has also been working with the National Institute of Child Health and Human Development (NICHD), the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), and the Office of Medical Applications of Research (OMAR) in the NIH Office of the Director on the State of the Science Conference on Fecal and Urinary Incontinence.

The majority of the diseases and disorders we address have no cure. We have yet to completely understand the pathophysiology of the underlying conditions. Patients face a life of learning to manage chronic illness that is accompanied by pain and an unrelenting myriad of gastrointestinal symptoms. The costs associated with these diseases are enormous; estimates range from between $25–$30 billion annually. The human toll is not only on the individual but also on the family. Economic costs spill over into the workplace. In essence, these diseases reflect lost potential for the individual and society. The IFFGD is a resource and provides hope for hundreds of thousands of people as they try to regain as normal a life as possible.

IRRITABLE BOWEL SYNDROME (IBS)

IBS strikes people from all walks of life affecting between 25 to 45 million Americans and results in significant human suffering and disability. This chronic disease is characterized by a group of symptoms, which include abdominal pain or discomfort associated with a change in bowel pattern, such as loose or more frequent bowel movements, diarrhea, and/or constipation. Although the cause of IBS is unknown, we do know that this disease needs a multidisciplinary approach in research and often treatment.

IBS can be emotionally and physically debilitating. Because of persistent bowel irregularity, individuals who suffer from this disorder may distance themselves from social events, work, and even may fear leaving their home.

In the House and Senate fiscal years 2004, 2005, and 2006 Labor, Health and Human Services, and Education Appropriations bills, Congress recommended that NIDDK develop an IBS strategic plan. The development of a strategic plan on IBS would greatly increase the institute's progress toward the needed research on this functional gastrointestinal disorder, as well as serve to advance our understanding of this disease, determine improved treatment options for IBS sufferers, and assist in recruiting new investigators to conduct IBS research. NIDDK is formulating an action plan for digestive diseases through the National Commission on Digestive Diseases and has indicated that IBS will be included as a component of this overall plan. IBS must be given sufficient attention, however, in order to increase the FGID and motility disorders research portfolio at NIDDK.

FECAL INCONTINENCE

At least 6.5 million Americans suffer from fecal incontinence. Incontinence is neither part of the aging process nor is it something that affects only the elderly. Incontinence crosses all age groups from children to older adults, but is more common among women and in the elderly of both sexes. Often it is a symptom associated with various neurological diseases and many cancer treatments. Yet, as a society, we rarely hear or talk about the bowel disorders associated with multiple sclerosis, diabetes, colon cancer, uterine cancer, and a host of other diseases.

Damage to the anal sphincter muscles; damage to the nerves of the anal sphincter muscles or the rectum; loss of storage capacity in the rectum; diarrhea; or pelvic floor dysfunction can cause fecal incontinence. People who have fecal incontinence may feel ashamed, embarrassed, or humiliated. Some don't want to leave the house out of fear they might have an accident in public. Most try to hide the problem as long as possible. They withdraw from friends and family, and often limit work or education efforts. Incontinence in the elderly burdens families and is a major reason for nursing home admissions, an already huge social and economic burden in our increasingly aging population.

In November 2002, the IFFGD sponsored a consensus conference—"Advancing the Treatment of Fecal and Urinary Incontinence Through Research: Trial Design, Outcome Measures, and Research Priorities." Among other outcomes, the conference resulted in six key research recommendations:

1. More comprehensive identification of quality of life issues associated with fecal incontinence and improved assessment and communication of treatment outcomes related to quality of life.
2. Standardization of scales to measure incontinence severity and quality of life.
3. Assessment of the utility of diagnostic tests for affecting management strategies and treatment outcomes.
4. Development of new drug compounds offering new treatment approaches to fecal incontinence.
5. Development and testing of strategies for primary prevention of fecal incontinence associated with childbirth.
6. Further understanding of the process of stigmatization as it applies to the experience of individuals with fecal incontinence.

The IFFGD has been working with the NICHD, NIDDK, and OMAR on a State of the Science Conference on Fecal and Urinary Incontinence. The goal of this conference will be to assess the state of the science and outline future priorities for research on both fecal and urinary incontinence; including, the prevalence and incidence of fecal and urinary incontinence, risk factors and potential prevention, pathophysiology, economic and quality of life impact, current tools available to measure symptom severity and burden, and the effectiveness of both short and long term treatment. Once the conference is completed, the NIH must prioritize implementation of the recommendations of this important conference.

GASTROESOPHAGEAL REFLUX DISEASE (GERD)

Gastroesophageal reflux disease, or GERD, is a common disorder affecting both adults and children, which results from the back-flow of acidic stomach contents into the esophagus. GERD is often accompanied by persistent symptoms, such as chronic heartburn and regurgitation of acid. But sometimes there are no apparent symptoms, and the presence of GERD is revealed when complications become evident. One uncommon complication is Barrett's esophagus, a potentially pre-cancerous condition associated with esophageal cancer. Symptoms of GERD vary from person to person. The majority of people with GERD have mild symptoms, with no visible evidence of tissue damage and little risk of developing complications. There are several treatment options available for individuals suffering from GERD.

Gastroesophageal reflux (GER) affects as many as one-third of all full term infants born in America each year. GER results from an immature upper gastrointestinal motor development. The prevalence of GER is increased in premature infants. Many infants require medical therapy in order for their symptoms to be controlled. Up to 25 percent of older children and adolescents will have GER or GERD due to lower esophageal sphincter dysfunction. In this population, the natural history of GER is similar to that of adult patients, in whom GER tends to be persistent and may require long-term treatment.

GASTROPARESIS

Gastroparesis, or paralysis of the stomach, refers to a stomach that empties slowly. Gastroparesis is characterized by symptoms from the delayed emptying of food, namely: bloating, nausea, vomiting or feeling full after eating only a small amount of food. Gastroparesis can occur as a result of several conditions; it can occur in up to 30 percent to 50 percent of patients with diabetes mellitus. A person with diabetic gastroparesis may have episodes of high and low blood sugar levels due to the unpredictable emptying of food from the stomach, leading to diabetic complications. Other causes of gastroparesis include Parkinson's disease and some medications, especially narcotic pain medications. In many patients a cause of the gastroparesis cannot be found and the disorder is termed idiopathic gastroparesis. Over the last several years, as more is being found out about gastroparesis, it has become clear this condition affects many people and the condition can cause a wide range of symptoms of differing severity.

ESOPHAGEAL CANCER

Approximately 13,000 new cases of esophageal cancer are diagnosed every year in this country. Although the causes of this cancer are unknown, it is thought that this cancer may be more prevalent in individuals who develop Barrett's esophagus. Diagnosis usually occurs when the disease is in an advanced stage; early screening tools are currently unavailable.

CHILDHOOD DEFECATION DISORDERS AND DISEASES

Chronic Intestinal Pseudo-Obstruction (CIP).—About 200 new cases of CIP are diagnosed in American Children each year. Often life threatening, the future for children severely affected with CIP is brightened by the evolving promise of cure with intestinal or multi-organ transplantation.

Hirschsprung's Disease.—A serious childhood and sometimes life-threatening condition that can cause constipation, occurs once in every 5,000 American children born each year. Approximately 20 percent of children with HD will continue to have complications following surgery. These complications include infection and/or fecal incontinence.

Functional Constipation.—Millions of children (1 in every 10) each year will be diagnosed with functional constipation. In fact, it is the chief complaint of 3 percent of pediatric outpatient visits and 10–25 percent of pediatric gastroenterology visits.

FUNCTIONAL GASTROINTESTINAL AND MOTILITY DISORDERS AND THE NATIONAL INSTITUTES OF HEALTH

The International Foundation for Functional Gastrointestinal Disorders recommends an increase of 5 percent for NIH overall, and a 5 percent increase for NIDDK and NICHD. However, we request that this increase for NIH does not come at the expense of other Public Health Service agencies.

We urge the subcommittee to provide the necessary funding for the expansion of the NIDDK's research program on functional gastrointestinal disorders (FGID) and motility disorders. This increased funding will allow for the growth of new research on FGID and motility disorders at NIDDK, a strategic plan on IBS, and increased public and professional awareness of FGID and motility disorders. In addition, we urge the subcommittee to continue to support and provide adequate funding to the Office of Research on Women's Health (ORWH) under the NIH Office of the Director, particularly for their Specialized Centers of Research on Sex and Gender Factors Affecting Women's Health (SCORs) program and the Building Interdisciplinary Research Careers in Women's Health (BIRCWH) program. The ORWH supports important research into IBS.

A primary tenant of IFFGD's mission is to ensure that clinical advancements concerning GI disorders result in improvements in the quality of life of those affected. By working together, this goal will be realized and the suffering and pain millions of people face daily will end.

Thank you.

PREPARED STATEMENT OF THE INDUSTRIAL MINERALS ASSOCIATION—NORTH AMERICA

It appears that the President's 2007 Budget for the Centers for Disease Control (CDC) includes a proposed reduction from $255.2 million to $250.2 million in funding for the National Institute for Occupational Safety and Health (NIOSH). IMA–NA notes that the fiscal year 2007 estimate carries forward fiscal year 2006 Conference language to move management and administrative costs ($34.8 million) from Occupational Safety and Health to Business Services Support. However, please note that the portion of the NIOSH budget to cover CDC overhead apparently has increased from 4.3 percent of NIOSH's budget in 2001 to nearing 14 percent in fiscal year 2007. This fee appears to be taking an increasingly larger share of NIOSH funds that otherwise would be dedicated to occupational safety and health research. IMA–NA encourages you to fund NIOSH as a stand-alone agency within the HHS organizational structure.

IMA–NA also favors increasing the fiscal year 2007 budget to expand the NIOSH in-house mining research program. Recent mining fatalities in the underground coal-mining sector have highlighted the need for a forward-looking initiative to improve mine emergency communications and to develop reliable technologies for tracking the location of underground miners. While IMA–NA supports these research initiatives, there is concern that other critical mine safety and health-related research important to the industrial minerals sector could be affected adversely. IMA–NA encourages you to fund NIOSH mining-related occupational safety and health research programs above current funding levels to address such critical issues as cumulative musculoskeletal trauma, dust control, and noise-induced hearing loss.

The Industrial Minerals Association—North America (IMA–NA) is a trade association organized to advance the interests of North American companies that mine or process industrial minerals. These minerals are used as feedstocks for the manufacturing and agricultural industries and are used to produce such essential products

are glass, paints and coatings, ceramics, detergents and fertilizers. The IMA–NA membership includes producers of ball clay, bentonite, borates, feldspar, industrial sand, mica, soda ash (trona), sodium silicate, talc and wollastonite. IMA–NA's membership also includes many of the suppliers to the industrial minerals industry, including equipment manufacturers, railroads and trucking companies, and consultants.

IMA–NA respectfully requests your support in opposing reductions in funding for occupational safety and health research, particularly as they affect mine safety and health. In the latter regard, we respectfully request additional funding above current levels.

PREPARED STATEMENT OF THE HHT FOUNDATION INTERNATIONAL

Mr. Chairman and honorable members of the committee, thank you for the opportunity to present my family's story in this testimony in support of the HHT Foundation's legislative initiative. I would like express my appreciation to Congresswoman DeLauro for all of her assistance to make this testimony possible.

My name is Jane Ribicoff Silk, I was fortunate to be the daughter of the former Senator Abraham & Mrs. Ruth Ribicoff, but I was unfortunate to have inherited Hereditary Hemorrhagic Telangiectasia (HHT). I am also the past president of the HHT Foundation, International.

HHT is a hidden killer: 20 percent of people with HHT die early or are disabled due to lung or brain involvement.

It is estimated that 70,000–100,000, or 1 in 3,000–5,000 Americans, are affected with Hereditary Hemorrhagic Telangiectasia (HHT). HHT is a genetic disorder, which affects blood vessels of the brain, spinal cord, lung, liver, gastrointestinal tract and most commonly, the nose. The affected blood vessels of the brain, spinal cord, and lung are prone to rupture and may result in stroke, hemorrhage or death. Bleeding from the nose and gastrointestinal tract can cause transfusion dependency and anemia, which can lead to heart failure. HHT can be treated successfully if correctly diagnosed. Children of an affected parent have a 50 percent chance of inheriting HHT.

DISABILITY AND DEATH CAN BE PREVENTED WITH PROPER DIAGNOSIS, SCREENING AND TREATMENT.

Nine of 10 people with HHT are not yet diagnosed due to widespread lack of knowledge by medical professionals.

HHT is a national health problem associated with high health care costs that has long been neglected.

From the time I was a very young child, I experienced the trauma of my grandmother's severe hemorrhages of the nose. The bleeding would not stop. The ambulance came. My grandmother went to the hospital where she received multiple transfusions of blood and came back home, her nose packed with gauze—and still bleeding. This was not an infrequent occurrence. In between her severe nosebleeds, there would be daily nosebleeds lasting for more than an hour. My grandmother died at the age of 67 from a transfusion tainted with hepatitis. The severity of my grandmother's bleeding, and the number of transfusions she needed to keep her alive, can now be prevented with modern therapy.

I realized at an early age that my mother, Ruth Ribicoff, also had a bleeding problem. She bled from her nose multiple times a week and every few months was hospitalized for transfusions due to blood loss. In her mid forties, it was discovered that she was also bleeding from her intestines. Additionally, she had HHT in her liver which caused her heart to pump harder and to enlarge. This eventually led to heart failure. She was often weak and never robustly energetic. Being the wife of a busy congressman, governor, cabinet member and senator put an additional social strain on my mother as she never knew at what inopportune moment she might get a bad nosebleed. Every purse she owned was stocked with a good supply of cotton.

In 1972, my mother died at the age of 64 of complications of the liver, intestinal bleeding and nosebleeds that are treatable today. Even today, it is still not recognized that 9 out of 10 people with HHT are not diagnosed.

My older brother, Peter, has carried the family burden of HHT almost his whole life and is the most impaired of all of us. His quality of life has been greatly diminished and he suffers every day. As a young boy he had occasional nosebleeds. When he was in his 20's he started getting backaches. He went to several doctors who could not help him, including Dr. Janet Travell, President Kennedy's personal back specialist. When he was in his 30's he began to lose sensation in the tops of his legs. An astute physician took some x-rays and noticed some dark spots around his spine.

The only doctor in the world at that time, who used dye to see the blood vessels in the spinal cord, was in Paris. So, my brother took his young family and went to Paris. During his hospitalization, he was told to go home and have exploratory surgery on his spine as there were malformations there that were most likely life threatening. Indeed, they were life threatening. During a 9-hour surgery, it was discovered that his HHT had affected the arteries of his spinal cord. He had had multiple hemorrhages over the years, which had caused his mysterious backaches, and if he had waited much longer, a massive hemorrhage of the malformed blood vessels of the spinal cord would have occurred—which would have either paralyzed him or killed him. So with meticulous care, each tangled and malformed artery snaking through his whole spinal column was tied off. It was not known if he would ever walk again. With extensive rehabilitation he did walk. But the loss of sensation caused by nerve damage was never regained. This has led to a continuously deteriorating condition for my brother. With a loss of sensation in his legs, he has become stooped over, uses a cane for balance and walks with a limp. Also due to his nerve damage, he has multiple complications with his bladder. For years he has had daily nosebleeds. He is in a weakened state all the time and his life has been permanently affected. If recognized early, his spinal cord malformation could have been treated and much suffering prevented.

Adding further insult to injury, my brother's daughter, Judith, a successful young woman, has a liver abnormality associated with HHT. When it was first discovered, doctors thought it was a tumor and almost did a biopsy which could have led to her loss of life. The doctors had no awareness of HHT. Fortunately, because of our experience with the Yale University HHT Center of Excellence and Dr. Robert I. White, Jr., she was taken care of and is now leading a normal life.

Last, but not least is myself. My nosebleeds started in adolescence and in my late teens and early 20's I had nosebleeds that could last 2 hours—and with HHT—you never have advance warning about when they are coming! I have led a pretty normal life, but have never had a lot of stamina.

When I was about 55, I went through a period of time of feeling completely exhausted. A check up at the doctor showed that my liver enzymes were unusually high. In the search for the cause, a CAT scan of my liver was done. What was discovered was something that the doctors in my community had never seen. They were ready to do a liver biopsy. I insisted that the lead doctor speak to the Yale HHT Center of Excellence. They explained that what they were looking at was not uncommon for people with HHT and should not be touched at that time. I am monitored regularly and as I get older, it is clear that of all of those in my family I am the most fortunate.

I have a daughter with HHT and granddaughter with HHT who may one day have children with HHT. I ask for funding so that not only my family, but all future generations will not have to live with HHT themselves or watch a family member slowly deteriorate or die a sudden preventable death.

HOW THE FEDERAL GOVERNMENT CAN HELP

Stroke, lung and brain hemorrhages can be prevented through early diagnosis, screening and treatment. Severe hemorrhages in the nose and gastrointestinal tract can be controlled through intervention and heart failure can be managed through proper diagnosis of HHT and treatments. Access to effective evidence-based interventions and treatment should be established through a joint legislative initiative between the 8 established National HHT Treatment Centers of Excellence and the National Center on Birth Defects and Disabilities Hereditary Blood Disorders Group with a legislative initiative of a $10 million set aside at the CDC through the HHS Appropriations bill in support of the 8 U.S. HHT Centers. These funds will be used to provide surveillance; create a multi-center clinical database to collect and analyze data; support epidemiological studies; document effectiveness or patient interventions, develop educational programs for health care programs and ultimately improve the quality of life for people living with HHT and future generations.

An additional $0.75 million is requested for the establishment of an HHT National Resource Center through a partnership between the CDC and the national voluntary agency representing HHT Families. These funds would be used to provide family support, education targeted to families and medical professionals, annual patient conferences, national and international scientific meetings and an aggressive research program. The CDC is ready and willing to work in partnership with the HHT Foundation to accomplish this mission.

Mr. Chairman, again, thank you for the opportunity to testify. On behalf of the HHT Foundation and all of its members I personally appeal to the committee for funding for the 8 HHT Centers of Excellence. We believe this will benefit those with

HHT and also reduce health care costs by the prevention of complications and the development of new therapies for this condition.

PREPARED STATEMENT OF THE LUPUS FOUNDATION OF AMERICA, INC.

As President and CEO of the Lupus Foundation of America, Inc. (LFA) I appreciate the opportunity to submit written comments for the record regarding funding for lupus related programs for fiscal year 2007. The LFA is the Nation's leading non-profit voluntary health organization dedicated to improving the diagnosis and treatment of lupus, supporting individuals and families affected by the disease, increasing awareness of lupus among health professionals and the public, and finding the causes and cure. As you may know, lupus is a debilitating, chronic autoimmune disease that causes inflammation and tissue damage to virtually any organ system; it can cause significant disability or even death. Lupus is the prototypical autoimmune disease; therefore, finding answers to questions about lupus may also provide understanding about other autoimmune diseases that affect 22 million Americans. The leaders and members of the LFA and the 1.5 to 2 million people suffering from lupus respectfully request the following for fiscal year 2007 to reduce and treat suffering from lupus:

—$29.7 billion for the National Institutes of Health (NIH) to support lupus research. Specifically, we urge Congress to direct NIH to support and bolster lupus research across all relevant institutes, centers, and offices.

—$1 million in new funding for The Office of Women's' Health at the Department of Health and Human Services (HHS) to support a sustained national lupus education campaign. This campaign is directed towards the general public and healthcare professionals who diagnose and treat people with lupus, with emphasis on reaching those individuals at highest risk—women of color—a health disparity that remains unexplained.

—$1.5 million for the National Lupus Patient Registry (NLPR) at the National Center for Chronic Disease Prevention and Health Promotion within the Center for Disease Control and Prevention (CDC) to sustain current epidemiological efforts, and expand the CDC's work to include all forms of lupus and all affected populations, particularly African Americans, Hispanics, and Asian Americans who are disproportionately at-risk for—and have worse outcomes associated with—lupus.

The purpose of the CDC lupus registry is to collect data and conduct lupus epidemiological studies to better understand and measure the burden of the illness, the social and economic impact of the disease, and stimulate additional private investment by industry in the development of new, safe and effective therapies for lupus. Existing epidemiological data on lupus is decades old and no longer reliable. Population-based epidemiological studies of lupus must be conducted at strategically-located sites throughout the Nation that will provide accurate data on all forms of lupus (i.e. systemic lupus, primary discoid lupus, drug-induced lupus, neonatal lupus, antiphospholipid antibodies) and the disparity among the various racial and ethnic populations.

To ensure that we begin to comprehensively study and understand the dramatic health disparities associated with lupus, the NLPR and associated epidemiological studies must be expanded to include additional sites that constitute a mix of urban and rural areas and contain academic centers with a track record and some existing infrastructure for performing epidemiological studies. Thank you.

I am Dr. Michael Madaio, Professor of Medicine at the University of Pennsylvania School of Medicine, and a lupus researcher. I have been funded for lupus research for over twenty years. I am proud to be affiliated with the Lupus Foundation of America as a member of the Medical Scientific Advisory Board and Chairman of the Medical Advisory Board for the Southeastern Pennsylvania Chapter of the LFA. While I am a nephrologist, since my research and clinical practice is focused on lupus, I really work day-to-day within the realms of nephrology and rheumatology as well as other medical specialties and subspecialty areas. I understand the importance of biomedical research funding and the impact that Federal research funding has had, does have, and can have on the lives of the 1.5 million people living with lupus and the 22 million Americans with other autoimmune diseases.

After a tragic 40 year dearth of new treatments to manage this often debilitating and devastating disease, the good news is that we finally are on the brink of major breakthroughs, thanks to research sponsored by the National Institutes of Health. Exciting research and strides in treatments for people with lupus are on the horizon and a sustained investment now in lupus research will speed the day to better treatments and a cure. Specifically, I am conducting extensive research on lupus nephri-

tis, which is kidney involvement in lupus disease. My field is advancing rapidly, due in large part to factors directly dependent on NIH funding:

—the burgeoning growth in the number of new animal models, including a wealth of informative transgenic and gene-targeted mutants;

—increased access to improved powerful technologies such as gene and protein arrays, now available at many institutions and to many investigators through NIH core facilities;

—new technologies that permit successful query of the very small amounts of human tissue typically available from patients and, collaboration across disciplines and across institutions to bring crucial expertise together;

—new insights into underlying biology and pathophysiology in immunity and lupus are constantly emerging;

—technologies to identify biomarkers are improved and accessible; and

—new approaches to therapy are being explored.

These endeavors are bearing fruit but they are highly dependent on NIH funding. If funding for the NIH is cut or level funded, it could cripple or paralyze current lupus research efforts.

As lupus is a systemic disease that can affect any organ or tissue elucidating pathogenesis (or cause) and treatments of lupus will have direct impact on many other autoimmune diseases (e.g. results and treatments translating to other diseases). Providing adequate resources to support lupus research will help the Nation turn the corner on finding better treatments or a cure for lupus while also supporting breakthroughs and progress for other disease states. It is important to note that the corollary is true: cuts in lupus research funding also will have an adverse effect on progress for lupus and for progress in related diseases. Cuts in NIH funding could bring to a standstill support of clinical trials and large observational studies, and could curtail research on those at highest risk for lupus, women of color; it also could negatively impact pediatric research at a time when researchers have just begun to undertake studies in important new areas. Furthermore, insufficient Federal funding also could slow much-needed genetic research when we are just discovering the critical components that may contribute to lupus and its effects. Therefore, it is critical that biomedical researchers be provided the necessary resources to continue seeking answers to the questions that will lead to better lupus treatments. Increased research funding will help deliver much-needed breakthroughs from the laboratory to patients in need.

The National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), the institute most involved in lupus research, is one of the smallest institutes at NIH. In the past two years there has been a decrease in research funding for NIAMS overall, with a ten percent decrease in new research grants. Currently, only 12–15 percent of the grant applications submitted to NIAMS receives funding. Further cuts will cause this rate to drop precipitously to below 10 percent next year. Just two or three years ago, funding levels were at 25–30 percent. Cuts in research funding, coupled with the rate of biomedical research inflation (3–4 percent per year), further erode NIAMS' ability to fund lupus research grant applications at the rate necessary to begin making real progress. As such, an increase above the rate of biomedical research inflation is necessary to allow NIH to sustain and build on its research progress resulting from the recent budget doubling while avoiding the severe disruption to that progress that would result from a lesser increase or cut.

Furthermore, in the proposed budget for NIAMS for 2007 there will be a loss of 10 training grants; each grant funds training for four physicians, mostly rheumatologists. Young and senior investigators alike are moving into other fields because of the lost of funding. Exacerbating the situation, medical schools are struggling financially due to public funding cuts thus eliminating any safety net for researchers that may have previously existed. As a result, young investigators are not attracted to lupus research which means there will be not be a future generation of lupus scientists and clinicians to do research. Moreover, after having attracted scientists to translational immunology in the last five to ten years, when funding was increasing, there is now a possibility we could lose both the current and next generation of young investigators. Increased funding is necessary to support an adequate number of training grants. Without research and training funds lupus researchers might be forced to become private practice physicians instead, leading to an imbalance in the health care system: sufficient numbers of physicians to treat lupus patients, but no new treatments with which to care for them, and no researchers to develop the cures of tomorrow.

We recognize and appreciate that Congress and the Nation face unprecedented fiscal challenges; however, we cannot afford to lose ground in biomedical research at such a promising time. The LFA looks forward to working with the subcommittee and others in Congress to reduce and prevent the suffering caused by lupus. We

stand ready to serve as a resource for any information you may need in this regard and thank you for this opportunity to submit written testimony for the record concerning fiscal year 2007 lupus related funding.

PREPARED STATEMENT OF THE MARCH OF DIMES BIRTH DEFECTS FOUNDATION

The 3 million volunteers and 1,400 staff members of the March of Dimes appreciate the opportunity to submit the Foundation's Federal funding recommendations for fiscal year 2007. The March of Dimes is a national voluntary health agency founded in 1938 by President Franklin D. Roosevelt to prevent polio. Today, the Foundation works to improve the health of mothers, infants and children by preventing birth defects, premature birth and infant mortality through research, community services, education, and advocacy. The March of Dimes is a unique partnership of scientists, clinicians, parents, members of the business community, and other volunteers affiliated with 52 chapters in every State, the District of Columbia, and Puerto Rico.

The volunteers and staff of the March of Dimes are deeply concerned that the funding recommendations in the President's Budget are not sufficient to meet the challenge of improving the health of women and children across the Nation. Continued under-funding of critical research and public health programs imperils the health of mothers and children today and in the future. In our judgment, the funding increases recommended below would lead to an immediate positive impact on reducing the incidence of preterm birth and birth defects, as well as making newborn screening for treatable metabolic and functional disorders more widely available.

NATIONAL INSTITUTES OF HEALTH

The March of Dimes joins the larger research community in recommending a 5 percent increase in funding for the National Institutes of Health (NIH), bringing total Federal support to just under $30 billion. The administration's fiscal year 2007 budget recommendation would necessitate absolute reductions in research investments as the levels of funding proposed are insufficient even to keep up with inflation and certainly will not sustain the necessary investment in medical research.

National Institute of Child Health and Human Development

The March of Dimes recommends a 5 percent increase for NICHD in fiscal year 2007 and an increase of at least $100 million over the next five years to boost prematurity-related research. Additional resources are needed to support research on the causes of preterm labor and delivery and on strategies for improving the care and treatment of infants born prematurely or at low birth weight. In addition, funding should be provided to enable the Institute to work with the Office of the Director of NIH to create a comprehensive strategic plan for this research that includes coordination of strategies and studies across multiple Institutes.

Since 1981, the preterm birth rate has increased 33 percent resulting in more than 500,000 premature births in 2004—that is 1 in 8 births. Preterm birth is the leading cause of death in the first month of life and, for those babies who do survive, one in 5 experiences multiple health problems including cerebral palsy, mental retardation, chronic lung disease, and vision and hearing loss. Preterm labor can happen to any pregnant woman, and the causes of nearly half of all premature births are unknown. This growing problem is a tragedy for families and expensive for the Nation. In 2003, the national hospital bill for the care of babies with a primary or secondary diagnosis of prematurity exceeded $18 billion, half of which was borne by Medicaid and other public programs and the remainder was charged to employers and families. Until we know how to prevent preterm labor, the worsening incidence of prematurity means that overall hospital charges will also spiral upward.

In recent years, the NICHD has made a major commitment to increasing our understanding of the factors that result in premature birth and to developing strategies to prolong pregnancy. But additional work is needed and adequate funding is key.

An area deserving more support is the collaborative Maternal-Fetal Medicine Units (MFMU) and Neonatal Research (NR) collaboratives. One clinical trial funded through the MFMU network reported a promising preventive intervention that relies on a derivative of the hormone progesterone. The incidence of preterm delivery was reduced by up to 30 percent in women who received weekly injections of the compound compared to the women who were given a placebo. The results of this intervention are impressive and additional funding is needed to support further clinical trials of this promising intervention.

Finally, the March of Dimes urges the subcommittee to include in its bill an increase of $57 million for the National Children's Study (NCS). While the amount may seem substantial, it is dwarfed by the cost of treating the diseases and conditions the study is designed to address. If allowed to go forward, the NCS will generate groundbreaking research that greatly increases our knowledge of the role family genetics and the environment play in the health and development of children. Planning for this study has been completed; the Vanguard sites have been designated. The project is poised to start implementation which will yield critical information for research on preterm birth. The NCS will prove a rich and ongoing information resource for use by scientists and clinicians to develop treatments and preventive measures tailored for the pediatric population. Failure to provide the resources needed for this study would be extremely shortsighted.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

Safe Motherhood/Infant Health

The National Center for Chronic Disease Prevention and Health Promotion, Division of Reproductive Health works to promote optimal reproductive and infant health. The March of Dimes recommends a $20 million increase in fiscal year 2007 to support expansion of research to identify risk factors and to develop strategies for preventing preterm birth. This can be accomplished with increased funding for the two programs described below:

1. The Pregnancy Risk Assessment Monitoring System (PRAMS) is a state-specific, population-based surveillance system designed to identify and monitor selected maternal behaviors and experiences before, during, and after pregnancy. Data collected through PRAMS is used to increase understanding of maternal behaviors and experiences and their relationship to adverse pregnancy outcomes, to improve maternal and child health programs, and to facilitate the dissemination of the latest research findings and clinical practice standards. The March of Dimes recommends an increase of $5 million to improve PRAMS so that CDC can develop national estimates on behavioral and demographic risk factors for preterm birth.

2. Epidemiological research conducted at CDC is vital to the prevention of preterm labor and delivery. The March of Dimes recommends an increase of $15 million for the expansion of basic etiologic research, research on women at risk for preterm delivery and the social and environmental factors contributing to higher rates of preterm delivery in African-American women. Increasing CDC's research activities related to preterm birth will lead to improvements in screening and early detection and new interventions for women at risk for preterm labor.

National Center on Birth Defects and Developmental Disabilities

The March of Dimes recommends a minimum of $135 million in fiscal year 2007 funding for the National Center on Birth Defects and Developmental Disabilities (NCBDDD). NCBDDD conducts programs to protect and improve the health of children by: (1) preventing birth defects and developmental disabilities; and (2) promoting optimal development and wellness among children with disabilities. Of particular interest to the March of Dimes is NCBDDD's birth defects program that includes surveillance, research and prevention activities. For fiscal year 2007, the March of Dimes requests an increase of $6 million to support surveillance and research and an additional $2 million for folic acid education. These modest increases are vital to making progress in reducing the incidence of birth defects.

In the United States, about 3 percent of all babies are born with a major birth defect. Birth defects are the leading cause of infant mortality accounting for more than 20 percent of all infant deaths every year. Children with birth defects who survive often experience long term physical and mental disabilities, and are at increased risk for developing other significant health problems. In fact, birth defects contribute substantially to the Nation's health care costs. According to CDC, the lifetime cost of caring for infants born with one of the 18 most common birth defects exceeds $8 billion annually.

NCBDDD provides funding to assist States with community-based birth defects tracking systems, programs to prevent birth defects and improve access to health services for children with birth defects. In 2006, CDC has been able to support only 15 States in their efforts to improve surveillance programs, down from 28 States in fiscal year 2004. Additional resources are sorely needed to help States seeking assistance.

The causes of nearly 70 percent of birth defects are unknown and it is therefore critical that the Committee increase funding for the National Birth Defects Prevention Study. This groundbreaking CDC initiative is being carried out by 9 regional Centers for Birth Defects Research and Prevention located in Arkansas, California,

Georgia, Iowa, Massachusetts, New York, North Carolina, Texas, and Utah. Each of these centers obtains data on infants with major birth defects through interviews with their mothers and biological samples that provide information about medical history, environmental exposures, and lifestyle before and during pregnancy. The study focuses on both genetic and environmental causes, including medication use during pregnancy, maternal diet and vitamin use. This study is an ongoing source of information for use in research on the causes of birth defects. With adequate funding this study has the potential to dramatically increase our understanding of the causes of birth defects and will provide information for developing effective preventive measures.

NCBDDD is conducting a national public and health professions education campaign designed to increase the number of women taking folic acid. CDC estimates that up to 70 percent of neural tube defects (NTDs), serious birth defects of the brain and spinal cord including anencephaly and spina bifida could be prevented if all women of childbearing age consume 400 micrograms of folic acid daily, beginning before pregnancy. Since fortification of grain products with folic acid in 1996, the rate of NTDs in the United States has decreased by 26 percent, but more must be done to educate every woman of childbearing age and the health professionals who treat them about the importance of taking folic acid daily.

Finally, the March of Dimes recommends that additional funds be provided to conduct surveillance and epidemiological research on cerebral palsy through the network already in place for autism (Centers of Excellence for Autism and Developmental Disabilities Research and Epidemiology). Cerebral palsy is one of the most common developmental disabilities and there is currently very limited surveillance and research being conducted.

National Immunization Program

If the Nation is to meet the Healthy People 2010 goals of vaccinating 90 percent of children and adults, CDC, States, and localities will need the resources required to reach those in need of immunizations. According to the CDC, nearly 25 percent of two-year-olds have not received all of the recommended vaccine doses. CDC's National Immunization Program provides grants to 64 State, local, and territorial public health agencies to reduce the incidence of disability and death resulting from 12 vaccine preventable diseases. The March of Dimes urges the subcommittee to continue its longstanding policy of ensuring that Federal vaccine programs are well funded. For fiscal year 2007, the March of Dimes recommends $802.4 million to ensure that the National Immunization Program has the resources it needs to account for vaccine price increases, introduction of new vaccines, and to implement recommendations by the Institute of Medicine.

Polio Eradication

The March of Dimes supports a funding level of $101.254 million for CDC's fiscal year 2007 global polio eradication activities. Level with fiscal year 2006, this funding would allow CDC to continue its supplementary immunization activities in the remaining endemic and high-risk countries in Africa and Asia and to move quickly to interrupt polio transmission in these regions. The U.S. Government must maintain its commitment to the worldwide eradication initiative that promises to save lives and reduce unnecessary health-related costs globally.

National Center for Health Statistics

The National Center for Health Statistics (NCHS) provides data essential for both public and private research and programmatic initiatives. The National Vital Statistics System and the National Survey on Family Growth, for example, are major sources of information on the utilization of prenatal care and on birth outcomes, including preterm delivery, low birthweight and infant mortality. Increased funding would enable CDC to introduce web-based technology to facilitate more rapid and accurate compilation of data obtained from health professionals and facilities. This information is used to track trends in birth outcomes and to support State birth defects registries. Data from NCHS surveys are also used to identify emerging trends and to optimize use of existing program resources.

HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

Newborn Screening

Newborn screening is a vital public health activity used to identify genetic, metabolic, hormonal and/or functional conditions in newborns that if left untreated can cause disability, mental retardation, and even death. Although nearly all babies born in the United States are screened for some genetic birth defects, the number of these tests varies from State to State. The March of Dimes recommends that

every baby born in the United States receive, at a minimum, screening for a core set of 28 metabolic disorders plus hearing deficiencies.

In fiscal year 2005 and fiscal year 2006, Congress provided funding for implementation of Title XXVI of the Children's Health Act of 2000; specifically, to fund the Regional Genetic Service and Newborn Screening Collaboratives that work to address the maldistribution of genetic services and resources and bring services closer to local communities. The March of Dimes supports an appropriation of $25 million to enable HRSA to improve the capacity of States to: (1) provide screening, counseling, testing, and special services for newborns and children at risk for heritable disorders; (2) educate health professionals and parents on the availability and importance of newborn screening; and (3) support States with technical assistance on the acquisition and use of new technologies and newborn screening services.

Healthy Start

The Healthy Start Initiative is a collection of community based projects focused on reducing infant mortality, low birthweight and racial disparities in perinatal outcomes. The March of Dimes strongly supports Healthy Start and urges continued funding for this important program to decrease this Nation's tragically high rate of infant mortality.

Maternal and Child Health Block Grant

In recent years, Federal funding for Title V of the Social Security Act, the Maternal and Child Health (MCH) Block Grant, has not kept pace with increased demand for services. Although the MCH Block Grant provides assistance for a growing number of community-based programs (such as home visiting, respite care for children with special health care needs and "wrap around" services for pregnant women and children enrolled in Medicaid and SCHIP), the funding level was reduced by $24 million in fiscal year 2006. In order for maternal and child health programs to shoulder responsibility for additional beneficiaries and services, funding must be increased. The March of Dimes recommends full funding of the MCH Block Grant at the authorized level of $850 million.

Consolidated Health Centers

Consolidated (Community) Health Centers are an important source of obstetric and pediatric care for more than 15 million individuals, approximately 40 percent of whom are uninsured. The Foundation recommends new funding sufficient to increase the number of centers and to improve the scope of perinatal services provided. Adding funds to this program would be consistent with the President's five-year plan to create and expand health center sites in 1,200 communities and to increase the number of patients served annually to more than 16 million.

Thank you for the opportunity to testify on the federally supported programs of highest priority to the March of Dimes. The Foundation's volunteers and staff in every State, the District of Columbia, and Puerto Rico look forward to working with members of the subcommittee to improve the health of the Nation's mothers, infants and children.

Prepared Statement of the Medical Library Association and the Association of Academic Health Sciences Libraries

Mr. Chairman, thank you for the opportunity to testify today on behalf of the Medical Library Association (MLA) and the Association of Academic Health Sciences Libraries (AAHSL) regarding the fiscal year 2007 budget for the National Library of Medicine (NLM). I am Marianne Comegys, Director of the Louisiana State University Health Sciences Center Library, Shreveport, Louisiana.

MLA, a nonprofit educational organization established in 1898, comprises health sciences information professionals with more than 4,500 members worldwide. Through its programs and services, MLA provides lifelong educational opportunities, supports a knowledgebase of health information research, and works with a global network of partners to promote the importance of quality information for improved health to the health care community and the public.

AAHSL is comprised of the directors of the libraries of 142 accredited United States and Canadian medical schools belonging to the Association of American Medical Colleges (AAMC). Together, MLA and AAHSL address health information issues and legislative matters of importance through a joint task force.

Mr. Chairman, the National Library of Medicine (NLM), on the campus of the National Institutes of Health (NIH) in Bethesda, Maryland, is the world's largest medical library. NLM collects material in all areas of biomedicine and health care, as

well as works on biomedical aspects of technology, the humanities, and the physical, life, and social sciences.

With respect to the Library's budget for the coming year, I would like to touch briefly on six issues: (1) the growing demand for NLM's basic services; (2) NLM's outreach and education services; (3) Emergency preparedness and response; (4) NLM's health information technology activities; (5) NLM's facility needs; and (6) NLM's infrastructure that supports the NIH Public Access Policy.

THE GROWING DEMAND FOR NLM'S BASIC SERVICES

Mr. Chairman, it is a tribute to NLM that the demand for its collections continues to steadily increase each year. These collections stand at 8.5 million items-books, journals, technical reports, manuscripts, microfilms, photographs, and images. Housed within the library is one of the world's finest collections of old and rare medical works. NLM is a national resource for all U.S. health science libraries through the National Network of Libraries of Medicine. Increasingly, it is also becoming an international resource for world-wide research collaboration.

Our Nation's healthcare providers, researchers, and consumers all use the library's collections, through the reading rooms or through interlibrary loan, and on the World Wide Web. Increasingly, NLM's collection is also available in digital form. NLM is developing a strategy for selecting, organizing, and ensuring permanent access to digital information. By doing so they are ensuring their availability for future generations. This availability of health information remains the highest priority for the Library.

Mr. Chairman, simply stated, NLM is a national treasure. I can tell you that without NLM our Nation's medical libraries would be unable to provide the quality information services that our Nation's healthcare providers, educators, researchers, and patients, have all come to expect.

Recognizing the invaluable role that NLM plays in our healthcare delivery system, the Medical Library Association and the Association of Academic Health Sciences Libraries join with the Ad Hoc Group for Medical Research Funding in recommending a 5 percent increase for NLM and NIH overall in fiscal year 2007.

OUTREACH AND EDUCATION

NLM's outreach programs are of particular interest to both MLA and AAHSL. These activities, designed to educate medical librarians, healthcare professionals and the general public about NLM's services, are an essential part of the Library's mission.

The Library has taken a leadership role in promoting educational outreach aimed at public libraries, secondary schools, senior centers, and other consumer-based settings. NLM's emphasis on outreach to underserved populations assists the effort to reduce health disparities among large sections of the American public.

NLM's "Partners in Information Access" program is designed to improve the access of local public health officials to health information. The establishment of additional programs across the country will go a long way towards ensuring that healthcare workers across America are familiar with NLM and the National Network of Libraries of Medicine. My own facility, the LSU Health Sciences Center in Shreveport, Louisiana, participates in this program. Through it, we are able to train public health workers on how to access health information online.

We ask the Committee to encourage NLM to coordinate its outreach activities with the medical library community.

PubMed Central

The medical library community also applauds NLM for its leadership in establishing PubMed Central, an online repository for life science articles. Introduced in 2000, PubMed Central was created by NLM's National Center for Biotechnology Information and evolved from an electronic archiving concept proposed by former NIH director Dr. Harold Varmus. The site houses 615,000 articles from 232 journals including the Proceedings of the National Academy of Sciences and Molecular Biology of the Cell.

The medical library community believes that medical librarians should continue to play a key role in the further development of PubMed Central and we are pleased that medical librarians are members of the PubMed Central Advisory Committee. Because of the high level of expertise health information specialists have in the organization, collection, and dissemination of medical literature, we believe that our community can assist NLM with issues related to copyright, fair use, and information classification. We look forward to continuing our collaboration with the Library as this exciting project continues to evolve.

MEDLINEplus

MEDLINEplus [http://www.nlm.nih.gov/medlineplus], a source of authoritative, full-text, health information resources from the NIH institutes and a variety of non-Federal sources, has grown tremendously in its coverage and its usage by the public. In January of 2006, MEDLINEplus had 8.6 million unique visitors research 67 million pages of health information (including information from over 1,250 organizations). MEDLINEplus's features include illustrated interactive patient tutorials, a daily news feed from the public media on health-related topics, and the NIH SeniorHealth website [http://www.nihseniorhealth.gov], a collaborative project between NLM and the National Institute on Aging.

"Go Local" is another new and exciting feature of MEDLINEplus. Go Local enables local and State agencies and others to participate by creating sites that connect the MEDLINEplus information seeker to local hospitals, pharmacies, doctors, and other health services. These agencies use the infrastructure created by NLM that makes this possible. Using Go Local, a search by topic on MEDLINEplus will lead the consumer to local services connected to that topic. Currently, there are fourteen localities participating in the Go Local service, and many more will be added in the near future. Through this service, NLM and MEDLINE are becoming increasingly valuable tools, not just for medical librarians and other health professionals but also for the health consumer.

Clinical Trials

Mr. Chairman, I also want to address another frequently used service offered by NLM—its clinical trials database [http://www.clinicaltrials.gov]. This listing of more than 27,000 Federal and privately funded trials for serious or life-threatening diseases was launched in February 2000 and currently logs more than 8 million page views per month and 25,000 visitors daily. The clinical trials database is a free and invaluable resource to patients and families interested in participating in cutting edge treatments for serious illnesses. The medical library community congratulates NLM for its leadership in creating ClinicalTrials.gov and looks forward to assisting the Library in advancing this important initiative.

EMERGENCY PREPAREDNESS AND RESPONSE

Since the late 1960s, NLM has been actively involved in disaster response and management. As a Louisiana resident, I am pleased to report about NLM's relief work in response to Hurricane Katrina. NLM's Specialized Information Services (SIS) Division compiled a Hurricane Katrina Web page on toxic chemical and environmental health information resources. The Web page provided links to information on chemicals that may have been released and on environmental concerns following the wind and flood damage. The page also linked to the Wireless Information System for Emergency Responders (WISER). WISER provides information on 400 of the most hazardous chemicals in NLM's Hazardous Substances Databank. It can be downloaded to a Personal Digital Assistant (PDA) or field laptop, providing first responders with ready access to basic emergency haz-mat information. At the request of the Environmental Protection Agency, NLM provided 15 PDAs loaded with WISER for the EPA National Decontamination Team to take with them when they were deployed to New Orleans. In addition, NLM's National Center for Biotechnology Information (NCBI) has provided assistance to the State of Louisiana in identifying Katrina victims with software tools that improve speed and accuracy of DNA identification.

In addition to NLM's efforts on the national level, the South Central Regional office of the NLM-supported National Network of Libraries of Medicine provided specific help to the libraries in its territory that were impacted by Katrina. When librarians were dispersed to remote sites, the Regional office purchased laptops and printers for them to use. Arrangements were also made for Katrina-area libraries to have free interlibrary loans. The South Central Regional office also created a blog, "Hurricane Katrina in the SCR," for librarians to post information regarding colleagues and building conditions. During the first few weeks after Katrina, when we were unsure of where our friends had relocated and how to contract them, the blog was an invaluable resource for helping us to find them and for suggesting ways to assist them.

Mr. Chairman, we applaud the success of NLM's outreach initiatives, particularly those initiatives that reach out to medical libraries and healthcare consumers. We look forward to continuing our work with the Library in fiscal year 2007 on these important programs.

HEALTH INFORMATION TECHNOLOGY AND BIOINFORMATICS

Mr. Chairman, NLM played a major role in creating and nurturing the field of medical informatics. For nearly 35 years, the Library has supported informatics research and training and the application of advanced computing and communications to biomedical research and health care delivery. Many of today's informatics leaders are graduates of NLM-funded informatics research programs at universities across the country. Many of the country's exemplary electronic health record systems (e.g., in Indianapolis, Vanderbilt, and Pittsburgh) benefited from NLM grant support. The Library began supporting informatics research that addresses information management problems relevant to disaster management several years ago. It has also funded innovative telemedicine projects in various rural and urban medically underserved communities, as models for evaluating the impact of telemedicine on cost, quality, and care. A leader in supporting, licensing, developing, and disseminating standard clinical terminologies for free nationwide use, NLM works closely with the National Coordinator of Health Information technology to promote adoption of interoperable electronic records. Through its National Center for Biotechnology Information, NLM creates and provides access to GenBank, the genetic sequence repository, and a wide array of related scientific data and analysis tools. These publicly accessible resources are speeding the pace of scientific discovery around the world, including important insights into the evolution of the flu. Building on this success, NLM will develop databases to manage the vast amount of genetic, medical and environmental information that will emanate from new HHS and NIH efforts to analyze genetic variation in groups of patients with specific illnesses and to devise new ways of monitoring personal environmental exposures that interact with genetic variations and result in human diseases.

We are pleased that NLM is supporting informatics research that addresses information management problems relevant to disaster management. Medical librarians and health information specialists have an important role to play in supporting these cutting edge technologies and in serving as important sources of health information for those displaced by disasters. We encourage Congress and NLM to continue their strong support of NLM's medical informatics and genomic science initiatives, at a point when the linking of clinical and genetic data holds increasing promise for enhancing the diagnosis and treatment of disease. MLA and AAHSL also support Health Information Technology initiatives in the Office of the National Coordinator for Health Information Technology (ONCHIT) and the Agency for Healthcare Research and Quality (AHRQ) that build upon initiatives housed at NLM.

NLM'S FACILITIES NEEDS

Mr. Chairman, over the past two decades NLM has assumed several new responsibilities, particularly in the areas of biotechnology, health services research, high performance computing, and consumer health. As a result, the Library has had tremendous growth in its basic functions related to the acquisition, organization, and preservation of an ever-expanding collection of biomedical literature. In order to complete these functions, NLM has had to expand its staff. NLM now houses 1,100 staff in a facility built to accommodate only 650. This increase in the volume of biomedical information and in the number of personnel has led to a serious shortage of space at the Library.

In order for NLM to continue its mission as the world's premier biomedical library, a new facility is urgently needed. The NLM Board of Regents has assigned the highest priority to supporting the acquisition of a new facility. The medical library community is pleased that Congress appropriated the necessary architectural and engineering funds for the design of the facility expansion at NLM in 2003. The community is also pleased that the American Center for Cures Act, (S. 2104) introduced in the Senate by Senator Lieberman, asks Congress to make a special effort to fund the expansion of NLM's facilities.

We encourage the subcommittee to provide the resources necessary to construct a new facility and to support the Library's health information programs.

NIH PUBLIC ACCESS POLICY

MLA and AAHSL support the goals of the NIH public access policy to create a central archive of NIH-funded research publications to advance science and enable NIH to better manage its research portfolio, and to provide electronic access to the public to NIH-funded research publications. We are concerned, however, that the current rate of participation in the voluntary policy is low—less than 4 percent. Information provided by the NIH Public Access Working Group indicates that the sub-

mission system is not difficult to use and that the majority of NIH-funded researchers appear to know about the policy. For these reasons, we concur with the conclusion of NLM's Board of Regents, that the NIH Policy cannot achieve its stated goals unless deposit of manuscripts becomes mandatory. We also support the Board of Regents' recommendation that NIH and NLM develop a careful plan for transitioning to a mandatory policy, and to provide clear guidance and a reasonable timetable to minimize burden on NIH-funded researchers and grantee institutions, and also to work with publishers to make it easy for them to submit articles on behalf of their NIH-supported authors.

We encourage Congress to continue to ask for periodic evaluation of the plan as it is implemented in the coming months and years.

Mr. Chairman, thank you again for the opportunity to present the views of the medical library community.

PREPARED STATEMENT OF THE MENDED HEARTS, INC.

The Mended Hearts, Inc. (MHI) is a national nonprofit organization that offers the gift of hope to heart patients, their families and caregivers for more than 50 years. Mended Hearts has 21,000 members operating through 280 community-based chapters across the country, with two in Canada. Chapters partner with more than 450 hospitals and cardiac care facilities in providing patient-to-patient support services. I have been appointed by the group as their legal representative—a volunteer position. I am a heart disease survivor.

About 30 years ago, I was diagnosed with a rare heart disease. After having chest discomfort and trouble breathing for more than two years, I was diagnosed with hypertrophic cardiomyopathy (HCM), a disease in which the heart enlarges. The heart muscle gradually thickens so much that heart cannot pump blood out effectively. The new heart muscle replacing the old heart tissue does not grow in the normal parallel pattern. Instead, it grows in a helter-skelter pattern. Studies show that 36 percent of young athletes who die suddenly have probable or definite hypertrophic cardiomyopathy, but it also affects men and women of all ages. HCM is one of the major causes of sudden death due to cardiac arrhythmias. There is no cure for HCM. However, medication may work, and there is surgery, which may alleviate the pain and discomfort, prolonging the patient's life. If surgery does not work, the alternative is a heart transplant, but donor organs are scarce. The doctor who made my diagnosis was trained at the National Institutes of Health's (NIH) National Heart, Lung, and Blood Institute (NHLBI).

Initially, I received several medications, which enabled me to engage in most activities. However, some activities, such as walking up hills, caused shortness of breath and severe chest pains. But, generally I could function normally. After about 10 years, the discomfort was increasing, and it became apparent that I was in serious trouble. I could not walk sixty feet without having to stop to catch my breath. Sometimes the pain was so severe that I would almost double over in the middle of the street. My wife told me later that my face would become gray. And the perspiration would pour off my body. The quality of my life had deteriorated so drastically that I knew I needed some treatment.

In 1988, I went to Georgetown Hospital for an angiogram—the gold standard for diagnosing heart problems. After the test, the cardiologist told me that he had bad news and worse news. The bad news was that I had a 95 percent blockage in my left anterior descending heart artery at the location known as the "widow-makers spot." The worse news was that I had a major chance of suffering a severe heart attack, with less than a 5 percent chance of survival because of the HCM. At this point, my wife was quietly crying and I was perspiring profusely.

Because Georgetown Hospital did not have the expertise to operate on my condition, they called the NIH to see if they would accept me as a patient. I was sent home pending notice from NIH. I knew that I had run out of alternatives. No matter what the results, I needed treatment and I needed it immediately.

Subsequently, the NIH accepted me. After entering the NHLBI on February 9, my surgery occurred on February 11, 1998. No matter how trite the expression, it is very true—the day after surgery was the first day of the rest of my life. The surgery, a left ventricular myotomy and myectomy, was considered drastic. I was later told that the mortality rate was as high as 10 percent. That surgery is still done in only a few hospitals. It is considered the gold standard for the treatment of HCM. This Murrow Procedure, in honor of the innovator, was developed and improved at the NIH.

Currently, there is a new experimental protocol in which the same effect is now being attempted by using alcohol to deaden the excessive heart tissue, instead of

removing a piece of heart muscle from the heart's main pumping chamber, as was done in my case.

Now, I am on medication for the rest of my life. My condition is progressive. More than 10 years ago, I was fitted with a pacemaker to ensure that my heart beats at the correct rate. I am 100 percent dependent upon my pacemaker. Without the pacemaker, there are times when my normal heart beat is so slow that I could die.

I am eternally grateful to the physicians funded by the NHLBI, particularly to Dr. Charles MacIntosh and his staff, for the gift of life. Because of this marvelous doctor and research, I have lived eighteen years free of pain. I have seen two children graduate from college, witnessed the birth of three grandchildren, and shared these years with a wonderful wife. And, I have been able to work at my profession—attorney at law.

I have had the gift of life restored to me. To express my gratitude for that gift, under the aegis of the Mended Hearts, Inc., I visit patients recovering from heart episodes at two hospitals: Washington Hospital Center and Washington Adventist Hospital. Last year MHI visited more than 228,000 patients and their families in our mission of support. We have also made 6,700 visits over the telephone to give succor to these patients.

If this tale of woe is not enough, about 3.5 years ago, I suddenly began to have mini-strokes. I experienced five episodes within 13 months. The last episode was just a year ago. Medication, including coumadin, now seems to have the incidents under control. Coumadin is a blood thinning drug that requires constant monitoring. At least once a month, I have to go to the hospital to get blood drawn from my arm to check the level of the drug.

To advance the fight against heart disease and stroke, I respectfully ask for the fiscal year 2007 appropriations in the following amounts:

—National Institutes of Health—$29.8 billion

—National Heart, Lung, and Blood Institute—$3.1 billion

—National Institute of Neurological Disorders and Stroke—$1.6 billion.

My experience and my continued life is proof that the research supported by the NIH benefits not just the patients at the Clinical Center, but throughout the United States. The benefits go worldwide too.

Cardiovascular diseases remain the major killer of men and women in the United States. Nearly 40 percent of people who die in the United States, die from cardiovascular diseases. From 1979 through 2003, cardiovascular operations and procedures increased 470 percent.

PREPARED STATEMENT OF THE MONTGOMERY COUNTY (MARYLAND) STROKE ASSOCIATION

My name is Susan Emery. I am the President of the Montgomery County Stroke Association and I am a stroke survivor.

Our Association conducts education and supports activities for stroke survivors, their family members, and caregivers. We serve people in the Maryland suburbs of Washington, D.C., and are fortunate to be in the same county as the National Institutes of Health. We have benefited on many occasions by the participation of NIH staff members in our membership meetings. They have been generous in sharing information with us about their research on stroke prevention and treatment.

On December 26, 1965, at the age of nine, I was playing a new game with my brother and a few friends at the kitchen table. That is the last thing that I remember. I was unconscious for the next two days. My mother first learned, incorrectly, that I had spinal meningitis. I was transferred to another hospital where my mother was told that I had little chance of survival. Yet, I am here, more than 40 years later, and I have survived a stroke.

People seldom associate strokes with children. These strokes are rare, but they do happen. There are about three cases of stroke per year in every 100,000 children aged 14 and under. One of the difficulties in dealing with strokes in children is getting the right diagnosis quickly. There are often delays in diagnosis of childhood stroke.

I spent two weeks in the hospital and the subsequent 4 months in intensive physical therapy. My 10th birthday was spent in the hospital, and I have a picture in my photo album of myself with my mother and a new friend. My right eye is turned down, my mouth is turned down, but I am still smiling. During the 4 months in therapy at Holy Cross in Detroit, I learned the basics: how to walk, how to talk, and how to move the fingers on my right hand. My mother followed the doctor's instructions and sent me back to school very quickly, where classmates helped me button and unbutton my coat and carry my books, and teachers taped papers to the

desk so I could learn to write again. I survived that 4 months, and would never wish to repeat it.

I have been in therapy six times in my life. I need to tell you about the one time that was the most important to my family. I was 26 years old and had just had my first child. I kept her safe, for I knew my limitations. I always used my left hand to support her. But when she was 6 months old, she got to be a little heavy, and twice, as I was putting her on the floor to change her diaper, my right hand slipped from under her buttocks. She fell only inches in both cases and did not even notice. But I noticed. I went in for 2 or 3 months of therapy close to Denver, Colorado, where I was living at the time. Here, for the first time, they helped my right hand and arm dexterity through occupational therapy. I also learned that I had aphasia—the inability to speak, write or understand spoken or written language because of brain injury—because I called things like fruit baskets "unicorns" instead of cornucopias. Instead of the word being the same, I picked a word that sounded the same. The therapists in Colorado worked with my mind and my body and I will forever be in their debt.

Close to 15 years ago, I made a new life for myself in Maryland. Here, I have been an outpatient at the National Rehabilitation Hospital three times: once for my right foot, once for my Achilles tendon, and once for my right knee. I have seen numerous physiatrists, all of whom are excellent in their field. I have also seen my fair share of therapists. Since I have had therapy on and off for most of my life, I can honestly say that the first few times you go in to see a therapist, you will come out hurting more than when you went in. But in the long run, they help tremendously.

On a work related note, I received a Bachelor of Science in 1978 from Michigan State University in Computer Science and worked for 12 years in the field. I started working in the telecommunications industry in 1990, and got a Master of Science from the University of Maryland, University College in Telecommunications Management. I now work for ITT Industries as a senior engineer on a contract supporting the Federal Aviation Administration's leased telecommunications activities, and have worked with the FAA for more than 10 years. I have done more than survive. I have become a productive member of society.

Stroke research has changed my life. Without the research carried out 40 to 50 years ago, I would not have benefited from electric shock therapy that made me understand the muscles that move my fingers. Without research done 30 years ago, I may not have been able to understand how to exercise my hand for dexterity. Without research performed 10 years ago, the people around me would not understand that they need to get me to the hospital quickly if ever I have another stroke. Without current support, researchers may never understand how to stop strokes before they happen or how to make current stroke survivors live healthier lives.

Stroke remains America's No. 3 killer and a major cause of permanent disability. An estimated 5.5 million Americans live with the consequences of stroke and about 1 in 4 is permanently disabled. Yet, stroke research continues to receive a mere 1 percent of the National Institutes of Health budget. I strongly urge you to significantly increase funding for the National Institutes of Health-supported stroke research, particularly for National Institute of Neurological Disorders and Stroke-supported stroke research. NIH stroke research is essential to prevent strokes from happening to children and adults in the first place, and to advance recovery and rehabilitation of those who survive this potentially devastating illness.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS

The National Association of Children's Hospitals (N.A.C.H.) is pleased to submit a statement for the record in support of the Children's Hospitals' Graduate Medical Education (CHGME) Program in the Health Resources and Services Administration. On behalf of the Nation's 60 independent children's teaching hospitals, N.A.C.H. very much appreciates Chairman Specter's and the subcommittee's early and continuing commitment over many years to provide full, equitable GME funding for these hospitals. CHGME seeks to give them a level of Federal support for their teaching comparable to what all other teaching hospitals receive from Medicare.

N.A.C.H. also appreciates the subcommittee's support for $300 million for fiscal year 2006. Ultimately this was reduced to $297 million, or less than level funding, due to a 1 percent across-the-board cut in discretionary spending. This marked the third consecutive year CHGME was reduced due to across-the-board cuts since Congress first agreed to appropriate $305 million for fiscal year 2004.

CHGME has been a success. Thanks to the program, Federal GME support to children's hospitals now approaches equity with Medicare GME support to adult

hospitals. CHGME has made it possible for children's hospitals to strengthen their training of pediatric providers at a time of national shortages, without having to sacrifice clinical or research programs. It has enabled them to have strong financial positions, which are essential for their capital intensive missions.

For fiscal year 2007, N.A.C.H. respectfully requests $330 million for CHGME funding. This amount would make up for erosion in funding over the last three years and address the cost of inflation, a critical factor in a program associated with both wage-related and medical teaching costs. Full funding would ensure the hospitals will have the resources necessary to train and educate the Nation's pediatric workforce. Given the challenges the subcommittee faces, we hope, at a minimum, CHGME can be maintained at level funding and not lose further ground in fiscal year 2007.

N.A.C.H. AND CHILDREN'S HOSPITALS

N.A.C.H. represents more than 130 children's hospitals. They include independent acute care children's hospitals, children's hospitals within larger medical centers, and independent children's specialty and rehabilitation hospitals. N.A.C.H. helps its members fulfill their missions of clinical care, education, research and advocacy for the health and well-being of all children.

Children's hospitals are regional and national centers of excellence for children with serious and complex conditions. They are centers of biomedical and health services research for children and serve as the major training centers for pediatric researchers, as well as a significant number of children's doctors. They also are major safety net providers, serving a disproportionate share of children from low-income families, and they are advocates for the public health of all children.

Although they represent less than 5 percent of all hospitals in the United States, the three major types of children's hospitals provide 41 percent of the inpatient care for all children, 42 percent of the inpatient care for children assisted by Medicaid, and the vast majority of hospital care for children with serious conditions such as cancer or heart defects.

BACKGROUND: THE NEED FOR CHGME

While they account for less than 1 percent of all hospitals, independent children's teaching hospitals train nearly 30 percent of all pediatricians, half of all pediatric specialists and the majority of pediatric researchers. These hospitals provide required pediatric rotations for many other residents and train more than 4,800 resident full time equivalents annually. Shortages of pediatric specialists across the Nation only heighten the importance of these hospitals.

Prior to initial funding of the CHGME program for fiscal year 2000, the eligible hospitals faced enormous challenges in maintaining their training programs. The increasingly price competitive medical marketplace was resulting in more and more payers failing to cover the costs of care, including the costs associated with teaching.

Because they see few—if any—Medicare patients, independent children's hospitals were essentially left out of Medicare GME funding, which had become the one major source of GME financing for other teaching hospitals. Independent children's hospitals received only 1/200th (or less than 0.5 percent) of the Federal GME support that all other teaching hospitals received under Medicare. This lack of GME financing, combined with financial challenges stemming from other missions, threatened the hospitals' teaching programs, as well as other services.

Safety Net Institutions.—Independent children's hospitals are a significant part of the health care safety net for low-income children. This critical mission puts the hospitals at financial risk. In fiscal year 2005, children assisted by Medicaid were, on average, more than 50 percent of all discharges from independent acute care children's hospitals. Yet, Medicaid, on average, paid only 79 percent of costs. Without disproportionate share hospital payments, Medicaid would cover, on average, only 73 percent of costs. Medicaid payment shortfalls for outpatient and physician care are even greater.

Independent children's hospitals also are essential providers of care for seriously and chronically ill children. The hospitals devote more than 75 percent of their care to children with one or more chronic or congenital conditions. They provide the majority of inpatient care to children with many serious illnesses—from children with cancer or cerebral palsy, for example, to children needing heart surgery or organ transplants. In some regions, these children's hospitals are the only source of pediatric specialty care. The services they must maintain to assure access to high quality, complex care for all children are often inadequately reimbursed.

Many of the independent children's hospitals also are a vital part of the emergency and critical care services in their regions. They are part of the emergency re-

sponse system that must be in place for public health emergencies. Expenses associated with preparedness add to their continuing costs in meeting children's needs.

Mounting Financial Pressures.—The CHGME program, and its relatively quick progress to full funding in fiscal year 2002, came at a critical time. In 1997, when Congress first considered establishing CHGME, a growing number of independent children's hospitals had financial losses; many more faced mounting financial pressures. More than 10 percent had negative total margins, more than 20 percent had negative operating margins and nearly 60 percent had negative patient care margins. Some of the Nation's most prominent children's hospitals were at financial risk. Thanks to CHGME, these hospitals have been able to maintain and strengthen their training programs.

Pediatric Workforce Development.—The important role CHGME plays in the continual development of our Nation's pediatric workforce is not lost on the larger pediatric community, including the American Academy of Pediatrics and Association of Medical School Pediatric Department Chairs. They support CHGME and recognize it is critical not only to the future of the individual hospitals but also to provision of children's health care and advancements in pediatric medicine overall.

CONGRESSIONAL RESPONSE

In the absence of movement to broader GME financing reform, Congress authorized the CHGME discretionary grant program in 1999 to address the existing inequity in GME financing for the independent children's hospitals. The legislation was reauthorized in 2000, through fiscal year 2005, and provided $285 million for fiscal year 2001 and "such sums as necessary" in the years beyond. Congress passed the initial authorization as part of the "Healthcare Research and Quality Act of 1999" and the reauthorization as part of the "Children's Health Act of 2000."

With this subcommittee's support, Congress appropriated initial funding for CHGME in fiscal year 2000, before the enactment of the program's authorization. Following enactment, Congress moved substantially toward full funding for the program in fiscal year 2001 and completed that goal, providing $285 million in fiscal year 2002. Subsequently, Congress appropriated $290 million in fiscal year 2003, $303 million in fiscal year 2004, $301 million in fiscal year 2005, and $297 million in fiscal year 2006. (In the last three years, the funding levels are net of across-the-board cuts in discretionary funding.)

Health Resources and Services Administration (HRSA).—CHGME funding is distributed through HRSA to 60 children's hospitals according to a formula based on the number and type of full-time equivalent residents trained, in accordance with Medicare rules, as well as the complexity of care and intensity of teaching the hospitals provide. Consistent with the authorizing legislation, HRSA allocates the annual appropriation in biweekly periodic payments to eligible independent children's hospitals.

"Adequate" Rating from Administration.—The Office of Management and Budget gave CHGME an "adequate" rating in 2003, using its Program Assessment Rating Tool (PART). The PART review found CHGME has a "clear purpose," is "effectively targeted," has specific "long-term performance measures" that focus on outcomes, and holds grantees "accountable for cost, schedule, and performance results."

CHGME SUCCESS

The annual CHGME appropriation represents an extraordinary achievement for the future of children's health and the Nation's independent children's teaching hospitals:

—Thanks to CHGME, the Federal Government has made substantial progress in providing more equitable Federal GME support to independent children's hospitals. The hospitals now receive about 80 percent of the level of Federal GME support that Medicare provides to other teaching hospitals. This is still not true equity, but it is dramatic improvement from the 0.5 percent of 1998.

—As a result of CHGME, children's hospitals have been able to make a substantial improvement in their contribution to the Nation's pediatric workforce, without having to sacrifice their clinical or research missions. From 2000 to 2004, without the CHGME hospitals being able to increase the numbers of general pediatric residents they trained, the Nation would have experienced a net decline in number of new pediatricians. During the same time, CHGME hospitals accounted for more than 80 percent of new pediatric subspecialty programs and more than 60 percent of the new pediatric subspecialists trained.

—CHGME has allowed children's hospitals to achieve strong financial positions. According to Moody's, before 2000, children's hospitals tended to have negative

to break-even financial margins. Since then, their margins have improved. CHGME is a major reason.

FISCAL YEAR 2007 REQUEST

N.A.C.H. respectfully requests that the subcommittee provide equitable GME funding for independent children's hospitals by providing $330 million in fiscal year 2007. Such funding is particularly important for a program that has wage-related and medical teaching costs and has experienced three years of successive reductions due to across-the-board cuts. Given the challenges the subcommittee faces, we hope CHGME at least can be maintained at level funding and not lose further ground in fiscal year 2007.

Adequate, equitable funding for CHGME is an ongoing need. Children's hospitals continue to train new pediatric residents and researchers every year. Children's hospitals have appreciated very much the support they have received, including the attainment of the program's authorized full funding level in fiscal year 2002 and continuation of full funding with an inflation adjustment in fiscal year 2003 and fiscal year 2004. Congress can regain this progress by providing $330 million in fiscal year 2007.

Continuing equitable CHGME funding is more important than ever in light of budget shortfalls in many States and pressures for significant reductions in State Medicaid spending. Because children's hospitals devote such a substantial portion of their care to children from low-income families, they are especially affected by cutbacks in State Medicaid programs.

Support for a strong investment in GME at independent children's teaching hospitals is also consistent with the repeated concern the subcommittee has expressed for the health and well-being of our Nation's children, through education, health and social welfare programs. And it is consistent with the subcommittee's repeated emphasis on the importance of enhanced investment in the National Institutes of Health (NIH) and in NIH support for pediatric research in particular, for which N.A.C.H. is grateful.

CHGME funding is essential to the ability of the independent children's hospitals to sustain their GME programs. At the same time, the program enables them to do so without sacrificing support for other critically important services that also rely on hospital subsidy, such as specialty and critical care services, child abuse prevention and treatment services, poison control centers, services to low-income children with inadequate or no coverage, mental health and dental services, and community advocacy, such as immunization and motor vehicle safety campaigns.

CONCLUSION

In conclusion, CHGME is a success. The program is an invaluable investment in children's health. The future of the pediatric workforce and children's access to quality pediatric care, including specialty and critical care services, depend upon CHGME. N.A.C.H. and the independent children's teaching hospitals are deeply grateful to the Chairman and subcommittee for your continuing leadership on behalf of children's hospitals.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS

SUMMARY

The proposed cuts in the fiscal year 2007 budget for the Centers for Disease Control and Prevention (CDC) continue a pattern of reduced funding for public health that gravely worries the Nation's local health departments. The National Association of County and City Health Officials (NACCHO) is particularly concerned about two funding streams that directly benefit local health departments, although the range of reductions in CDC's budget threaten overall work in prevention that we fully support.

Last year, funding for State and local bioterrorism and public health preparedness was cut by $95 million, more than 10 percent. NACCHO understands that this will result in a cut of about 12 percent in the cooperative agreement funding that goes directly to States and four large cities. The Preventive Health and Health Services block grant program, the other major source of CDC funding to local health departments, was cut by $19 million, which was 16 percent below the actual fiscal year 2005 funding made available to grantees, and almost 25 percent below the fiscal year 2005 appropriated amount. The fiscal year 2007 budget freezes preparedness funds and eliminates the block grant. Taken together, these reductions will seri-

ously compromise the ability of the Nation's governmental public health system to fulfill its mission of protecting and promoting health.

Local public health departments work every day on the front lines to combat threats to the health of their communities. They can ill afford substantial reductions in Federal support for their roles as first responders to bioterrorism and other public health emergencies. Moreover, local public health departments receive about 40 percent of the Preventive Health and Health Services block grant (PHHS) funds. These enable them to carry out programs ranging from prevention of heart attack and stroke to combating West Nile virus. In States where local health departments rely exclusively on these funds to run prevention programs activities to reduce the burdens of preventable disease will cease.

At a time when the Nation is engaged in urgent work to protect the homeland from terrorists and natural disasters, as well as to stop an epidemic of obesity, it is profoundly counterproductive and irrational to reduce support for local programs that are the first line of defense against the greatest threats to the health of communities. NACCHO urges Congress to continue funding these two CDC programs at levels no less than those in fiscal year 2005. Those levels are $927 million for State and local bioterrorism preparedness and $131 million for the Preventive Health and Health Services block grant.

STRENGTHENING THE GOVERNMENTAL PUBLIC HEALTH SYSTEM TO IMPROVE HOMELAND SECURITY REQUIRES SUSTAINED FUNDING

Congress recognized in 1997 an unmet need to strengthen the Nation's capacity to respond to an act of bioterrorism and initiated funding for bioterrorism preparedness in fiscal year 1999. The initial funding of about $121 million (which included $51 million solely for stockpiling medications) assisted CDC and State and local health departments to begin examining what plans and resources were necessary. After 9/11 and the anthrax outbreaks in the fall of 2001, Congress increased bioterrorism funding markedly and included $940 million for building State and local capacities, of which about $870 million was actually made available to States and localities. The Department of Health and Human Services got these funds out to States and three large cities via cooperative agreements very promptly, far ahead of other homeland security funds for States and localities.

Substantial bioterrorism preparedness funds for improving all aspects of preparedness have actually been in the hands of State health departments since August 2002. Local public health departments, many of which have been funded for less time, are justifiably proud of the progress they have made.

Extensive response plans, developed in collaboration with local emergency management systems, have been made. Numerous "tabletop" and real field exercises have tested local capabilities. Mass vaccination clinics have taken place, some as part of a real response to flu vaccine shortages. Communications systems and equipment that enable rapid electronic information exchange among and by health departments to their communities are operational. Improved systems for disease detection are in place.

Local health departments have engaged hospitals, physicians, and others in the private sector to develop further their roles in responding to a serious disease outbreak. Complex logistical arrangements needed to distribute medications or equipment from the Strategic National Stockpile to stricken populations have been developed.

In some locations, genuine public health crises, such as flu vaccine shortages or an influx of evacuees from the Gulf Coast in the wake of Katrina, have demanded a response. In the act of responding, local health departments and their community partners continually identify new challenges and new ways to improve their ability to respond. Improving a locality's ability to detect a disease outbreak promptly and to contain it swiftly is a continuous process of training, exercising, and improving plans based on these exercises. Interrupting that process through funding cuts would take the Nation's public health preparedness backwards, not forward. New capacities that are now in place cannot be sustained without sustained funding.

Congress appropriated supplemental funding of $350 million to assist States and localities in pandemic influenza preparedness. These funds are greatly appreciated, but they cannot fill the gaps left by other funding cuts. The narrow range of activities permitted by CDC's grant guidance for the first $100 million now available to States adds to the tasks required of health departments, but the sums available are insufficient to enable hiring new personnel to carry them out. Moreover, the production and exercise of plans for any biological event, including pandemic influenza, is never a one-time activity. Meaningful progress requires a continuous process of training, exercising and improvement that involves not merely public health re-

sponders, but all community partners that are part of any response, including law enforcement, emergency management, hospitals, schools, and a host of private sector partners.

The Nation has a long way to go before every citizen enjoys the best possible protection by disease detection and response systems that work as quickly as humanly possible. Providing this protection is the job of the governmental public health system. No other entity can do it. NACCHO urges Congress to reverse the cuts in funds available to local public health departments, the Nation's first responders to bioterrorism.

THE PHHS BLOCK GRANT IS A LINCHPIN FOR PREVENTION

Local public health departments receive approximately 40 percent of the Preventive Health and Health Services block grants nationally. The proportion varies among States from less than 5 percent to almost 100 percent. The block grant funds fulfill three critical purposes. First, they enable States to address critical unmet public health needs. The coexistence of other Federal categorical public health funds does not mean that sufficient funds are available to address all public health needs. They are not. Improving chronic disease prevention through screening programs and programs that promote healthy nutrition and physical activity are prime examples of activities to which many jurisdictions devote PHHS funds. Forty percent of fiscal year 2004 block grant funds were spent on chronic disease prevention, including prevention of obesity, stroke, heart disease, cancer, diabetes, and dental caries.

Second, PHHS funds provide some flexible funding to address unexpected problems or problems unique to a particular geographic area. West Nile virus, a fully preventable disease spread to humans by mosquitoes, is one good example. Third, PHHS fund provide leverage for more funds and in-kind resources from non-Federal sources. In one southern State, local health departments collectively used $2.77 million in block grant funds to establish new prevention programs and generate $5 million in additional resources for those programs.

States are fully accountable to the Department of Health and Human Services for their expenditures of block grant funds and must report how much money they spend by specific program area. In those States where local health departments receive a significant amount of PHHS funds from the State, local prevention efforts will diminish. Local and State health departments are key leaders and providers of population-based prevention programs. They work to keep prevention in the public eye and build on programs that have been proven effective in reducing disease and preventing premature death. As health care costs escalate, reducing the Nation's commitment to prevention by eliminating the PHHS block grant, weakening state and local public health departments, is unwise and uneconomic.

The National Association of County and City Health Officials (NACCHO) is the organization representing the almost 3,000 local public health departments in the United States.

PREPARED STATEMENT OF THE NATIONAL COALITION FOR OSTEOPOROSIS AND RELATED BONE DISEASES

The National Coalition for Osteoporosis and Related Bone Diseases (Bone Coalition) is pleased to comment on the fiscal year 2007 budget for the National Institutes of Health (NIH) as it relates to bone research. The Federal investment made to date goes a long way towards improving the bone health of our citizens and we are appreciative of the Committee's leadership over the years. We also congratulate the Committee for recognizing the complexities of the issues in the bone field and including language in the fiscal year 2006 committee report directing the NIH to establish a "Bone Health Research Blueprint."

The recent Surgeon General's Report on bone health and osteoporosis illustrates the large burden that bone disease places on our Nation and its citizens. The Bone Coalition is committed to reducing the impact of bone diseases through expanded basic, clinical, epidemiological and behavioral research and through education leading to improvement in patient care. The Coalition participants are leading national bone disease organizations—the American Society for Bone and Mineral Research, the National Osteoporosis Foundation, the Osteogenesis Imperfecta Foundation, and the Paget Foundation for Paget's Disease of Bone.

Bone diseases such as osteoporosis, osteogenesis imperfecta, and Paget's disease of bone pose a significant public health and economic challenge.

—*Osteoporosis*.—Is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased susceptibility to fractures of the hip, spine, and wrist. It remains widespread across all popu-

lations. This is due to several factors, such as the aging of our population, the prevalence of secondary osteoporosis, and low bone mass that is common in immobilized patients and nursing home populations. Secondary osteoporosis, resulting from numerous chronic medical conditions and the long-term use of many medications, causes osteoporosis and related fractures in children, adolescents, and young adults. Over 10 million Americans have osteoporosis, the majority of whom (80 percent) are women, and 34 million more have low bone mass, placing them at increased risk for this disease. One out of every two women and one in four men over 50 will have an osteoporosis-related fracture in her/his lifetime. Osteoporosis is responsible for more than 1.5 million fractures annually, and mortality and morbidity following both spine and hip fractures is high when compared to unaffected peers. The estimated national direct expenditures for osteoporosis and related fractures total $18 billion (2002 dollars) each year.

—*Paget's Disease of Bone*.—The second most prevalent bone disease after osteoporosis—is a chronic skeletal disorder that may result in enlarged or deformed bones in one or more regions of the skeleton. Excessive bone breakdown and formation can result in bone that is dense, but fragile. Complications may include arthritis, fractures, bowing of limbs, neurological complications, and hearing loss if the disease affects the skull. Prevalence in the population ranges from 1.5 percent to 8 percent depending on the person's age and geographical location. Paget's disease primarily affects people over 50.

—*Osteogenesis Imperfecta (OI)*.—Causes brittle bones that break easily due to a problem with collagen production. For example, a cough or sneeze can break a rib, rolling over can break a leg. Besides fragile bones, people with OI may have hearing loss, brittle teeth, short stature, skeletal deformities, and respiratory difficulties. OI affects between 20,000 to 50,000 Americans. In severe cases fractures occur before and during birth. In some cases, an affected child can suffer repeated fractures before a diagnosis can be made. Undiagnosed OI may result in accusations of child abuse.

—*Cancer Metastasis to Bone*.—A frequent complication of cancer is its spread to bone (bone metastasis) that occurs in up to 80 percent of patients with myeloma, 70 percent of patients with either breast or prostate cancer, and 15 to 30 percent of patients with lung, colon, stomach, bladder, uterine, rectal, and renal cancer causing severe bone pain and pathologic fractures. Only 20 percent of breast cancer patients and 5 percent of lung cancer patients survive more than 5 years after discovery of bone metastasis.

According to Dr. Zerhouni, ". . . we are facing great challenges in [the area of bone research]: an aging population at increasing risk for bone problems; the attendant costs of bone disease, both in human and financial terms; and the need for more physician-scientists to continue the important work of discovery, treatment, and prevention."

Bone diseases take many forms and cause complications such as fractures, chronic pain, hearing loss, brittle teeth, respiratory difficulties, bone metastasis from cancer, and neurological complications that reduce people's quality of life and cost society billions of dollars. These challenges in bone research cut across numerous institutes/centers at the National Institutes of Health. They traverse the focus of individual Institutes and require an interdisciplinary scientific approach.

At the NIH, as part of the Roadmap Initiative, a series of awards have been established that will make it easier for scientists to conduct interdisciplinary research and an Office of Portfolio Analysis and Strategic Initiatives has been established to coordinate trans-NIH initiatives. The health problems in the bone field require new approaches. We believe these new efforts will remove obstacles to scientific progress and better coordinate the discoveries of tomorrow.

NIH-supported research in bone health has led to important discoveries and has generated new treatments and pharmaceutical products. It must be recognized that new discoveries and breakthroughs could come from any areas of biomedical research and could result in new treatments and eventually a cure for bone diseases.

—Research has taught us that those with low bone mass are at risk for osteoporosis. These individuals can then address their risk with exercise, diet, other behavioral and lifestyle changes, and medication.

—Research has decreased fracture risk and extended the lifespan to normal for people with OI.

—Research has identified drugs which improve the quality of life of people whose cancer has metastasized to bone.

—Research has led us to develop simple, non-invasive and accurate tests that can determine bone mass and help predict fracture risk.

—Research has identified and demonstrated a variety of drugs that can reduce bone loss and fractures, and even build new bone. Thirty years ago, there was no treatment for osteoporosis.
—Research has helped us to understand the need for weight-bearing exercise to build and maintain bone in order to reduce fracture risk. Falling can be reduced by strength-building exercise that increases balance and flexibility.

But much remains to be done. A concentrated effort is required to address bone health. The Coalition is particularly interested in NIH support for the following in fiscal year 2007:

—Research is needed into the pathophysiology of bone loss in varied populations and in targeted therapies to improve bone density and bone quality according to the etiology of osteoporosis. In addition research is needed to identify patients at risk for fracture who do not meet current criteria for osteoporosis, as well as to study the effects of available and developing osteoporosis treatments on the reduction of fracture risk in these patients.
—NCI, NIAMS, NIA and NIDDK must support research to determine mechanisms and to identify, block and treat cancer metastasis to bone. Furthermore, NCI must expand research on osteosarcoma to improve survival and quality of life and to prevent metastatic osteosarcoma in children and teenagers who develop this cancer.
—Although bone mineral density has been a useful predictor of susceptibility to fracture, other properties of the skeleton contribute to bone strength, including mechanical loading (exercise) and mechanisms of biomineralization. However, at this time little is understood as to how these properties assist in the maintenance of bone strength. Support of this research by NIA, NIAMS, NIBIB, NICHD, NIDDK, and NHLB will achieve identification of these parameters and lead to better prediction for prevention and treatment of bone diseases such as osteoporosis, osteogenesis imperfecta, bone loss due to kidney disease, and heart attacks due to hardening of the arteries.
—Thousands of children and adolescents nationwide suffer from musculoskeletal disorders and malformations, many of which have devastating effects on mortality and disability. NIAMS and NICHD must support research focusing on mechanisms of preventing fractures and improving bone quality and correcting malformations, on innovations in surgical and non-surgical approaches to treatment, and on physical factors that affect growth.
—Diseases such as osteogenesis imperfecta, fibrous dysplasia, osteopetrosis, and Paget's disease are caused by poorly understood genetic mutations. In Paget's disease, underlying genetic defects can also be exacerbated by environmental factors. NIAMS, NICHD, NIDCR, and NIDDK must support research on genetic defects that cause bone disease.
—57.9 million Americans are injured annually, more than one-half incur injuries to the musculoskeletal system. In the United States, back pain is a major reason listed for lost time from work and sports injuries are increasing in "weekend warriors" of both sexes. NIAMS, NIA, and NCCAM must study ways to better understand the epidemiology of back pain, improve on existing diagnostic techniques for back pain, as well as to develop new ones. NIAMS, NIBIB, NIDDK and NIA must expand research to improve diagnostic and therapeutic approaches to significantly lower the impact of musculoskeletal traumas, and on research on accelerated fracture healing, the use of biochemical or physical bone stimulation, and bone substitutes such as hydroxyapatite and allogeneic tissues.

To move this research forward, Congress must provide sufficient funding to the National Institutes of Health to sustain the robust research atmosphere in which to address the challenges in the bone field. The revolution in genetics/genomics that has provided new tools and databases and the powerful new imaging devices must not be hindered. Research must continue to be accelerated in order to improve the health of the Nation.

RECOMMENDATIONS

The National Coalition for Osteoporosis and Related Bone Diseases supports a 5 percent increase for the National Institutes of Health (above the fiscal year 2006 funding level), as recommended by the Ad Hoc Group for Medical Research, along with the National Health Council, the Campaign for Medical Research and Research!America.

The recent Surgeon General's Report on bone health and osteoporosis illustrates the large burden that bone disease places on our Nation and its citizens. We support the establishment of a "Bone Health Research Blueprint" to address the need for interdisciplinary approaches to research and increased coordination of research ef-

forts. We believe that more deliberately integrated activities in the areas of bone research at NIH and at extramural institutions will move our science more rapidly to discoveries that will preserve health and cure disease.

Thank you for the opportunity to submit our statement regarding the fiscal year 2007 budget for the National Institutes of Health.

PREPARED STATEMENT OF THE NATIONAL COMMUNITY ACTION FOUNDATION

REQUESTING LEVEL FUNDING FOR THE FISCAL YEAR 2007 COMMUNITY SERVICES BLOCK GRANT, LIHEAP, AND HEAD START PROGRAMS

I first want to convey the deep gratitude of every one of the Nation's 1,100 Community Action Agencies to Chairman Specter and Senator Harkin for their leadership in amending the Budget Resolution to preserve critical domestic programs.

We are requesting that the subcommittee go forward with the Chairman's original intent of restoring all the programs that are reduced or eliminated by the President's 2007 budget request. This remains the correct priority in light of the extreme and, in our opinion, destructive constraints placed on all domestic discretionary spending. Of course, this one-year policy is no substitute for a renaissance of investment in healthy children, in the workforce of tomorrow, in the health of the public, and in the science that will sharpen America's competitive edge in 21st century trade.

The following facts on the threat to Community Action's top priority programs—CSBG, Head Start and LIHEAP—will indicate how important to Community Action are the strategic decisions facing the subcommittee.

The Community Service Block Grant (CSBG) is the funding that underwrites the unique assignment of CAAs: their responsibility to convene local leadership to make a plan with the low-income community that implements a mix of strategies to bring in new investment and social resources. CAAs sustain their communities' long-term commitment to expand access to new opportunities for their residents who need to become more productive and more self-sufficient. Fifty two Senators have written the subcommittee opposing the President's request.

If CSBG is reduced or eliminated, important community institutions will be lost.

In Pennsylvania:

—Mercer County's Weed & Seed Community Revitalization effort, Micro-enterprise Development project that makes small business owners out of former low-income workers and the Elm Street revitalization project will cease.

—That CAA would also end its sponsorship of three HUD projects (22 units) which are home to special needs populations; those precious subsidized apartments will be rented out at "fair market value".

—In Venango and Crawford Counties services in the areas of youth development, supportive housing services, and education would be eliminated.

—The Pittsburgh and Philadelphia CAAs would close, their services absorbed into a variety of city government departments;

—Outreach Centers across the State's rural areas would be shuttered.

In Iowa, eliminating CSBG means:

—91 outreach centers will close; these are the local offices where programs operate, meet both those in need and offer the entire community space for groups working on local betterment.

—The same will befall dozens of food pantries supported by CAA warehouses, storage and trucking in which Churches and other volunteers participate.

—633 homeless children in the Hawkeye area will have no preventive screenings.

—117 elderly individuals around Davenport will lose the chore assistance services that have allowed them to remain in their own homes.

—In Des Moines the vast community gardens project will shut down and three thrift stores the low-income community depends on will close;

—In Dubuque, the financial literacy education initiative will end.

Even more ominous is the prospect that no future partnerships or new initiatives will be imagined and developed; in the past two years, CAAs across America have used their CSBG as the flexible "venture capital" that supports the efforts to develop partnerships, plan projects, and raise and package resources. Among the results that are permanently changing their communities are: numerous dental clinics, housing developments, job creation projects, energy services for all the community, and clean water supply facilities. CAAs have developed and improved communities with permanent investments such as these for four decades. Ending CSBG dams up the stream of emerging community infrastructure and services and cuts

the ties that keep public-private local partnerships that coordinate their resources to change local conditions.

CAAs serve one-third of the Head Start and Early Head Start participants.—The requirements for program quality have increased as science's knowledge of early childhood; the expectations for the depth and number of services and professional care are high. The staff cannot receive cost of living increases, much less the salaries their skills merit, without reductions in enrollment. The threat to children's hard won gains grows with each reduction. CAAs will be forced to deny places to 6,300 of the 19,000 qualified children that are anticipated to go unserved under a freeze in fiscal year 2007 Head Start funding.

Finally, LIHEAP must be maintained at least at its current level.—This year the Congress, led by the Senate with many Members of this subcommittee in the vanguard, at last got LIHEAP right.

The $3.1 billion the Chairman and Ranking Member supported for the fiscal year 2006 program is desperately needed. We have surveyed our member agencies who, collectively, deliver more than a third of the LIHEAP program nationwide. They are confident that, in spite of the late start, all the new resources will be distributed either to consumers who where shut out of the first round of assistance or to participants whose initial benefits were too low to buy them more than a few short weeks worth of fuel.

The "Sunbelt" programs that nearly doubled their initial grants when the supplemental funds were appropriated are making especially speedy and good use of the resources they have long needed. It is surprising, but true, that low-income consumers in Florida, the Gulf Coast States and the Southwest spend nearly as high a percentage of their income on energy bills as do Midwesterners. That is just one reason it is essential that most of 2007 LIHEAP funds be distributed according to the statutory formula, as is the case with the fiscal year 2006 funding.

Further, the only good reason for a large contingency fund is to correct for the extreme effects of the formula factors that deny the cold States a fair share of appropriations above $2 billion. A presidential contingency reserve for crises should only be an amount sufficient to meet an unpredicted need—such as a major natural disaster—during the period of awaiting major supplemental emergency legislation. Winter and Summer do not qualify as unexpected events; neither do high prices. The level and timing of program funding cannot be abandoned to Presidential politics.

The Department of Energy predicted on April 11 that 2007 home fuel prices will essentially remain at this year's record levels.(EIA Short-term Energy Outlook) Last year, its April prediction for prices in normal 2005–06 winter weather turned out to be about 10 percent under the prices we faced in this unusually mild winter. Next winter, the energy markets will afford no relief for struggling LIHEAP-eligible customers. LIHEAP must, at least, be sustained.

Community Action will be beside and behind this subcommittee's fight for a fair budget for America's priorities in every way possible in every part of this Nation. Thank you for considering these views and for your strategic and moral leadership.

PREPARED STATEMENT OF THE NATIONAL AHEC ORGANIZATION

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS:

1. Increase funding for the Health Professions and Nursing Education programs under Title VII and Title VIII of the Public Health Service Act to at least $550 million for fiscal year 2007.
2. Restore funding for area Health Education Centers (AHECs) to the fiscal year 2003 level of $33.141 million.
3. Restore funding for the Health Education Training Centers to the fiscal year 2003 level of $4.371 million.

Mr. Chairman, and members of the subcommittee, I am pleased to present testimony on behalf of the National Area Health Education Centers Organization (NAO). NAO is the professional organization representing the Area Health Education Centers (AHECs) and the Health Education Training Centers (HETCs).

I am Kathleen Vasquez, director of the Ohio Statewide AHEC program, director of the Medical University of Ohio's AHEC program, and the co-chair of the National AHEC Organization (NAO)'s Public Policy Committee.

AHECs develop and support the community based training of health professions students, particularly in underserved rural and urban areas. They also provide continuing education and other services that improve the quality of community-based health care. HETCs use the infrastructure of the AHECs to address the needs of

diverse populations with persistent and severe unmet health needs. In 5 border and 6 non-border States, HETCs train and support Community Health Workers to provide health information and services in their communities. Last year alone HETCs provided the initial training and continuing education for over 5,000 Community Health Workers.

Since 1980, the Ohio AHEC program has played a vital part in training the State's healthcare workforce. Through a community-based education infrastructure, the delivery of direct patient care is expanded and a pipeline of professionals is maintained to provide future care. That pipeline of future professionals who will go on to practice in rural and underserved areas is maintained through collaborative partnerships with community health centers (CHCs) and the National Health Service Corps (NHSC). These partnerships allow the AHECs to help the Nation's health professions workforce to address timely issues such as bioterrorism, flu prevention and the nursing shortage.

COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS

Community Health Centers are dedicated to providing preventive and ambulatory health care to the most uninsured and underinsured populations by placing point-of-service facilities in these areas. A March 2006 study published in the Journal of the American Medical Association (JAMA) found that community health centers report high percentages of provider vacancies, including an insufficient supply of dentists, pharmacists, pediatricians, family physicians, and registered nurses. These shortages are especially pronounced in rural community health centers. Because Title VII programs (including AHECs and HETCs) have a successful record of training providers who work in underserved areas, the study recommends increased support for Title VII as the primary means of alleviating the health professions shortage in rural areas. The article serves as an important reminder that the success of CHCs is highly dependent upon a well-trained clinical staff to provide care.

The Ohio AHEC program has worked closely with Community Health Centers to promote and support their complementary missions through the co-sponsorship of educational programs, the development of clinical training sites, and the recruitment of talented students. The Ohio AHEC program places students in rotations at Community Health Centers all over the State. For example, the Northeast Ohio AHEC places nursing, nutrition, and health education students in rotations at the Health and Dental Centers of Community Action Agency of Coloumbiana County. The Summit Portage AHEC places third year medical students in an "exploratory experience" elective with the Akron Community Health Resources. Other medical students are placed at the Ohio North East System, which has three Community Health Centers in Youngstown, Warren, and Alliance. The AHECs affiliated with the Medical University of Ohio place students at the expansion community health center in Lima as well as at the only designated migrant health center in Ohio, Community Health Services in rural Fremont. A network of over 500 physicians volunteer their time to teach the students at these Community Health Centers along with students placed in other underserved and rural areas of the State.

Through another partnership with the Ohio Primary Care Association (OPCA), Ohio AHECs organized a statewide health literacy and diabetes conference, with accompanying health literacy train-the-trainer components. Through this type of train- the- trainer education, Ohio AHECs have maximized limited resources to build capacity to continue providing education beyond the initial offering. Many of the participants in this health literacy and diabetes conference worked at a Community Health Center.

The leadership of the Community Health Centers and the AHECs in Ohio often work closely together. I, as the Director of the Ohio Statewide AHEC program, serve on the board of a Community Health Center. The Executive Director of that same Community Health Center serves on the board of the Sandusky AHEC. And the Executive Director of the Health and Dental Centers of Community Action Agency of Columbiana County is a member of the Eastern Ohio AHEC Board. These partnerships allow the AHEC program to help Community Health Centers in Ohio to recruit, train, and retain well-qualified health professionals who are passionate about serving in a rural or otherwise underserved area.

AHECs also undertake a variety of programs related to the placement and support of National Health Service Corps (NHSC) scholars and loan repayment recipients. The Ohio AHEC is a contractor of the NHSC "SEARCH" program. The AHECs, in collaboration with the Ohio Academy of Family Practice and the Ohio Department of Health, annually recruit 70 students, develop training sites, monitor placements and advise on individual community projects. These students will gain

experience and exposure to practice in rural, underserved and especially community health center sites throughout the State.

BIOTERRORISM AND FLU PREVENTION

Ohio AHECs provide nearly 400 continuing education programs, which are attended by 11,000 practicing professionals. These providers do not have to leave their communities or arrange coverage in order to attend these programs, because the programs are brought to them in their local communities. The topics of continuing education programs are determined by the needs of the practitioners in the community, so timely topics such as avian flu and bioterrorism have been recently provided.

Ohio AHECs have stepped in to provide health professionals with the latest updates on surveillance, reporting, risk communication, treatment, and other responses to the threat of bioterrorism. In rural areas of the State, AHECs bring in downlinks and sponsor bioterrorism preparedness programs. Ohio AHECs have provided preparedness training for clinicians at the Community Health Centers, and also provided train- the- trainer education programs at 4 regional locations. In addition, some of our sister AHEC programs are already heavily involved in public education for flu prevention.

NURSING SHORTAGE

Contrary to what may be commonly understood, persistent and severe shortages exist in a number of health professions. Chronic shortages exist for all health professions in many of our Nation's underserved communities, and substantial shortages exist in all communities for some high-need professions such as nursing.

Historically, the supply of and demand for health care professionals has waxed and waned in a manner that produced cycles of shortage and excess. However, it is reasonable to believe that the current shortages are of a different and more persistent nature. First, the breadth and depth of shortages are greater than at any time in the past. More disciplines are in short supply, more sites of care (hospitals, nursing homes, home care agencies, and clinics) are experiencing shortages, and the duration of vacancies is longer. Second, the demand for health care services is steadily and inexorably increasing due to the aging population and the advances in medical technology. Third, the health care provider population is aging itself. Fourth, the resources with which the health care industry might respond to shortages are inadequate. Due to the squeeze of managed care, provider institutions are unable to increase salaries, and due to cuts in government funding, educational institutions are unable to expand class sizes. Finally, the career opportunities available to women, who historically have dominated the nursing profession, have expanded greatly.

Currently, AHECs and HETCs are working with schools of nursing, State nursing associations, Community Health Centers, and the National Health Service Corps, to increase the number of qualified applicants to nursing schools, increase minority enrollment in nursing schools, expand the number of community-based nursing training sites, and retrain nurses who wish to re-enter the profession.

JUSTIFICATION FOR FUNDING RECOMMENDATIONS

Mr. Chairman, I respectfully ask the subcommittee to support our recommendations to increase funding for the health professions and nursing education programs under Title VII and Title VIII of the Public Health Act to at least $550 million for fiscal year 2007. Our recommendations are consistent with those of the Health Professions and Nursing Education Coalition (HPNEC). 56 of your colleagues (led by Senators Reed and Roberts), signed a letter to the subcommittee, stating that restoring funding to Title VII health professions programs is vital to reversing health professions shortages in the Nation's neediest communities.

Two of the Title VII programs, AHECs and HETCs, improve access to primary and preventive care through community partnerships, linking the resources of academic health centers with local communities. AHECs and HETCs have proven to be responsive and efficient models for addressing an ever-changing variety of community health issues, including bioterrorism, flu prevention, and the nursing shortage. In order to continue this potential, additional Federal investment is required. We request that in fiscal year 2007 you restore funding to the fiscal year 2003 levels of $33.141 million for AHECs, and $4.371 million for HETCs.

PREPARED STATEMENT OF THE NATIONAL COALITION FOR HEART AND STROKE RESEARCH

My name is Jack Owen Wood. I solicit your support for more aggressive Federal funding for research into prevention and treatment of the sister diseases, stroke and heart disease. Strokes and heart attacks are occurring at an alarming rate.

I am representing the National Coalition for Heart and Stroke Research. The coalition consists of 18 national organizations representing more than 5 million volunteers and members united in support for increased funding for heart and stroke research. Members of the Coalition include: American Academy of Neurology; American Academy of Physical Medicine and Rehabilitation; American Association of Neurological Surgeons; American College of Cardiology; American College of Chest Physicians; American Heart Association; American Neurological Association; American Stroke Association; American Vascular Association Foundation; Association of Black Cardiologists; Child Neurology Society; Children's Cardiomyopathy Foundation, Inc.; Congress of Neurological Surgeons; Heart Rhythm Society; Mended Hearts, Inc.; National Stroke Association; Society of Interventional Radiology; and Society for Vascular Surgery.

I will deal primarily with one man's personal experience with stroke and its functional and financial costs—my own. I have only the use of my right arm.

I was born in 1937, raised in Vicksburg, Mississippi, earned an engineering degree at Mississippi State University and currently reside in Port Orchard, Washington. I worked for the Boeing Company in Seattle, am a former Director of the Washington State Energy Office, served as Director of Cost and Revenue Analysis and as the Forecasting Manager for a major Northwest Area Natural Gas Utility until May 1, 1995.

On May 1, 1995, at the age of 57, I was stricken and severely disabled by my stroke. Two years later I experienced a triple bypass heart operation. You might say I've "been there and done that" for both major cardiovascular diseases. So you see, I am an expert.

Years ago I was offered an exciting and rewarding volunteer opportunity. I was asked to lead the "JACK WOOD STROKE VICTOR TOUR" for the American Heart Association.

The JACK WOOD STROKE VICTOR TOUR was a 5-State lobbying tour. Through it I tried to meet personally with every Northwest Congressional representative on his or her home turf (in Alaska, Idaho, Montana, Oregon and Washington). In each meeting I was joined by local people, stroke survivors and their families and medical professionals. I told my story and asked them to join the Congressional Heart and Stroke Coalition and to support increased Federal funding for heart and stroke research.

I am proud to say I traveled to 18 communities and met personally with 28 members of our delegation or their staff.

One of the most powerful memories for me was the frequency in which Members of Congress or staff members related their personal experience with stroke. One member I spoke to lost both parents to stroke. I suspect many of you have stories too.

I realize your interest is greater than the physical impact of my stroke. Your concern must include the financial impact, not only to me, but also on our country from increased health care costs and lost productivity and its many implications.

I have confronted the difficult and painful task of calculating that cost to me. Besides being a man whose stroke took his ability to pick up and play with his grandchildren and his livelihood, I remain a statistician at heart. I could not resist calculating and telling that part of my story. But please remember my story is not dissimilar to that of many of the 5.5 million stroke survivors in the United States. Many of whom were stricken in their prime earning years. Who in a matter of moments, seemingly without warning, are transformed from a contributor and provider to a receiver and patient.

Allow me to highlight three figures that I feel sum up my data and should be important to you. I estimate that my stroke at age 57:

—Reduced my earnings before retirement age 65 by more than $600,000.

—Subsequently, the cost to the Federal Government in lost income and other taxes, early Medicare payments and Social Security disability payments is more than $320,000.

—My HMO spent approximately $150,000 to respond to and treat my stroke.

—One man, over $1 million.

About 700,000 Americans will suffer a stroke this year costing this Nation an estimated $58 billion in medical expenses and lost productivity.

Earlier I described a stroke as occurring seemingly without warning. All too often as in my case, people either don't know or ignore the signs of a stroke, even one in progress. When my stroke hit I denied it. It took me two days after my stroke to acknowledge it and seek help. Because of research into new treatments, we now have tPA, a clot-busting drug, which if administered within 3 hours of the onset of stroke symptoms, can dramatically reduce the damage of clot-based strokes. Had I recognized and acknowledged my stroke, gone to a hospital with a neurologist on staff and had there been tPA, the impact of my stroke most certainly would have been lessened.

What is even more painful to me is that my impending stroke could have been detected. Unfortunately, we need to create easier and less expensive diagnostic techniques so that effective diagnostics can be given routinely as part of regular health exams. And they must be covered through insurance.

I am not asking for your sympathy. Instead, please think of me as two of the ghosts in the famous Dickens' story. Please don't misunderstand, I am not casting you as Scrooge. See me as both the ghosts of things past and things yet to be. I too am here to tell you, the future, which I represent, needs not be. It is largely up to you.

I hope my story and estimate of the cost of my stroke convinces you that taking on stroke and heart disease through increased research, leading to better prevention, diagnosis and treatment is fiscally responsible. The human and financial costs are astronomical.

Thank you for your past support of research.

PREPARED STATEMENT OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY

Mr. Chairman and distinguished members of the subcommittee, we appreciate the opportunity to submit written testimony on behalf of the National Multiple Sclerosis Society. Multiple sclerosis (MS) is a chronic, unpredictable and often disabling disease of the central nervous system. Symptoms range from numbness in the limbs, to loss of vision, memory deficits, and in some instances partial or total paralysis. The progress, severity and specific symptoms of MS in any one person can vary and cannot yet be predicted, but advances in research and treatment are giving hope to those affected by the disease.

Since its inception in 1946, the Society's highest priority has been to end the devastating effects of MS by supporting research aimed at finding the cause of MS, providing better treatments, and ultimately discovering a cure. In 2006, the National MS Society will spend over $40 million on MS research supporting over 350 MS investigations. By the end of 2006, the Society cumulatively will have expended some $500 million since awarding its first three grants in 1947. This represents the largest privately funded program of basic, clinical, and applied research and training related to MS in the world.

Any effort to conquer MS will require the collective efforts of many individuals as well as private and public organizations. The Federal Government is a critical partner in the fight against MS and must continue its vital role in furthering the scientific understanding of MS. To this end, the Society supports the following proposals related to Federal efforts:

—There is a great need to determine how many Americans have MS. We therefore ask that the National Institutes of Health (NIH) collaborate with the Centers for Disease Control/Agency for Toxic Substances and Disease Registry (CDC/ASTDR), the Society and other MS organizations to begin the task of establishing the incidence and prevalence of MS.

—There is a great need to find treatments for the primary-progressive form of MS (PPMS). We therefore ask that NIH bring additional research focus to the primary-progressive form of MS.

—There is a great need to develop laboratory tests to help physicians easily diagnose and monitor MS. We therefore ask that NIH expand its efforts to identify biomarkers for MS.

—There is a great need provide effective rehabilitation services to Americans with MS. We therefore urge that the National Institute on Disability and Rehabilitation Research (NIDRR) in the Department of Education fund one additional Medical Rehabilitation Research and Training Center for MS and take steps to stimulate individual research projects in MS.

—There is a great need to sustain the country's research enterprise and to accelerate the discovery of life-changing treatments for MS. We therefore ask that Congress increase fiscal year 2007 NIH funding by 5 percent.

The National MS Society has had a long and productive relationship with the NIH, particularly with National Institute of Neurological Disorders and Stroke (NINDS). Our founder, Sylvia Lawry, helped spearhead the legislation that established NINDS in 1950 and the Society has been pleased to work with the NINDS on many areas of mutual interest. Indeed, we extend our thanks to NINDS Director, Dr. Story Landis, and key members of her staff, for meeting the Society's senior leadership to explore collaborative opportunities. We look forward to continued discussions with Dr. Landis and are eager to initiate similar discussions with the leadership of other NIH institutes.

The Federal investment in the NIH and the NIDRR plays a major role in MS research. At the NIH, there are two other institutes that conduct or fund the majority of MS research: the NINDS, which funds 75 percent, and the National Institute of Allergy and Infectious Diseases (NIAID), which funds about 20 percent. The National Center for Medical Rehabilitation Research (NCMRR—a unit of the National Institute of Child Health and Human Development) also funds a small amount of MS research specifically targeting rehabilitation issues. In addition to the NIH, the NIDRR through the Department of Education invests in MS research.

For fiscal year 2006 and fiscal year 2007, it is estimated that NIH expenditures on MS research will be approximately $109 and 108 million, respectively. For fiscal year 2006 and fiscal year 2007 NIDRR expenditures on MS research will be approximately $1.6 million per year out of a total budget of $107 million per year.

—While this demonstrates one measure of the Federal investment in MS research, this amount pales in comparison with the annual direct and indirect disease cost—approximately $23 billion for all people with MS in the United States.[1]

INVESTING IN RESEARCH PRIORITIES RELEVANT TO MS

The National MS Society recognizes that new discoveries and breakthrough findings could come from almost any area of biomedical research and could apply to the primary concern of our members: finding a cure for MS. NIH plays THE major role in maintaining our country's preeminence in the biotechnology industry and provides world-wide leadership in health research and discovery. We thus encourage Congress to focus on NIH as a whole, and on agencies of particular relevance to our concern, knowing that a well-funded Federal research enterprise will benefit all of us.

Determining how many Americans are affected by MS.—An area in critical need of attention is determining the incidence, prevalence, and distribution of MS. The last national study of incidence and prevalence of MS in the United States took place more than 30 years ago. Since that time the population of the United States has changed dramatically in size, composition, and distribution. Moreover, numerous questions have arisen concerning possible ethnic, geographic, and local variations in the distribution of MS. Knowledge concerning these distributions and possible causal factors may provide important information concerning the nature of MS and its triggers. Rational policy formulation for MS health care requires up-to-date information concerning numbers and characteristics of persons with MS down to the State level.

We are pleased to note that CDC/ASTDR has taken an important step in addressing this issue by convening a workshop to discuss a proposal for setting up national surveillance systems for MS and amyotrophic lateral sclerosis (ALS). The Society was pleased to participate in this meeting and looks forward to collaborating with CDC/ASTDR in planning of regional pilot studies of methods to establish incidence and prevalence of MS, and ultimately the design and deployment of a national or multi-regional surveillance system for MS. Establishment of such systems, however, is beyond the resources of the Society. We therefore urge NINDS and other appropriate NIH institutes to collaborate with the CDC/ATSDR and to allocate funds for the conduct of the critical pilot studies and to support a national effort to accurately measure incidence and prevalence of MS.

Finding new treatments for primary-progressive MS.—Advances in immunology have provided clinicians with powerful tools to better understand the underlying causes of MS, leading to new therapeutic advances. Although there are FDA-approved treatments for relapsing MS, there are still no approved treatments for progressive MS. The primary-progressive form of MS (PPMS) is characterized from the

[1] Based on a 1994 Duke University study, indexed for 2004 by the National MS Society, the average annual cost of MS is estimated at $57,500 per person due to lost wages, increased medical care and other expenses. Nationwide, there are an estimated 400,000 people with MS.

onset by the absence of acute attacks and instead involves a continuous and gradual clinical decline.

Approximately 10 percent of individuals are diagnosed with PPMS from the onset. Clinically, this form of the disease is associated with a lack of response to any form of the approved MS therapies. This leads to the concept that PPMS may in fact be a very different disease as compared to relapsing-remitting MS. The Society identifies the study of primary-progressive MS as an area that merits greater attention by the research community in order to increase our understanding of PPMS and to have effective therapies for this progressive form of the disease. In the upcoming year, the Society encourages NIH to help the Society address this underserved area of MS research.

Helping physicians with diagnosis and treatment.—The complexity of MS poses many challenges for both diagnosis and treatment of the disease. Biomarkers, substances that are detectible in blood or other body fluids by laboratory testing, are a promising tool for physicians since they could aid in diagnosis, treatment selection, and prediction of disease course. In addition, valid biomarkers will be very useful in evaluating the effectiveness of new drugs.

The fundamental importance of biomarkers for MS has been recognized by the NIH Autoimmune Disease Coordinating Committee and NINDS, which sponsored a workshop on this topic in 2004. Moreover we are pleased to note that NINDS has provided $4 million for a major biomarker discovery effort as part of a large-scale clinical trial, CombiRx. The CombiRx trial is evaluating whether or not a combination of approved MS therapies is more effective in treating MS than individual therapies. We applaud NINDS for its efforts to-date and urge that NINDS and other NIH institutes work with the Society to expand their efforts to support research directed at the discovery and validation of biomarkers for MS.

EXPANDING THE SCOPE OF FEDERAL SUPPORT FOR MS RESEARCH

In addition to efforts at the NIH, the Society is pleased to note that for more than 20 years, NIDRR has funded a Medical Rehabilitation Research and Training Center (MRRTC) for MS. However, the institute's overall investment in MS research remains limited, $1.6 million in fiscal year 2006 and fiscal year 2007. It is dismaying that the current NIDRR portfolio includes only 4 projects related to MS whereas spinal cord injury, with a prevalence less than that of MS, has 39 active projects in the NIDRR portfolio.

Since the advent of FDA-approved MS disease-modifying treatments in 1993, persons with MS have had access to therapeutics which can slow the progression of disability. However, in order to maintain maximum levels of independence, persons with MS need rehabilitation to address residual deficits. Unfortunately, due to the limited support for MS rehabilitation research, we know relatively little about the efficacy of rehabilitative interventions in MS. We therefore urge the NIDRR to increase its support for MS rehabilitation research through the funding of at least one additional MRRTC along with initiatives to stimulate individual research projects.

OVERALL NIH FUNDING INCREASE FOR FISCAL YEAR 2007

The Society is deeply concerned that NIH may face a fourth year of overall low funding increases. This low funding level endangers the potential breakthroughs and discoveries that motivated Congress to complete a five-year campaign to double NIH's budget in 2003. In fact, the trend toward flat or slightly decreased NIH funding could put NIH on a trajectory to un-double its budget because the annual cost of inflation cannot be covered.

Furthermore, we are gravely concerned that the current annual NIH investment in MS research of $110 million is projected to drop by $1 million in 2007 and another $1 million in 2008. This trend jeopardizes progress toward a cure and new treatments for MS. Indeed, we remind the committee that in the 1990's, it was the NIH's basic and clinical research that contributed greatly to the development of the first disease modifying drugs for MS. Now there are 6 such drugs approved for MS therapy, and the NIH is funding a major trial to test whether combining drugs can enhance their benefit.

Moreover, NIH-funded research catalyzes industry efforts to develop drugs in many ways. Industry tells us that developing biomarkers that can measure the progression of MS could dramatically enhance their efforts to develop drugs. Over the last several years, advances in brain imaging for MS have taken a major step towards the goal of MS biomarkers. The NIH has a major effort underway to identify additional methods to measure the progression of MS, this is another step toward increased understanding of MS. Moreover, because of these advances in understanding of MS, biotech and pharmaceutical companies currently have more than

a dozen drugs for MS in various stages of clinical testing. Despite these significant efforts, the number of new drug applications to the Food and Drug Administration continues to decline. The Society fears that this negative trend will be accelerated by continued reductions in NIH-funded research.

A lack of Federal funds for biomedical research and MS research, in particular, will also force junior and senior researchers to leave the scientific workforce, further slowing the pace of research. Such an outcome would mean that substantial investments biomedical research would have been squandered, and replenishing this workforce would take a generation. We therefore urge Congress to:

—Appropriate a 5 percent fiscal year 2007 funding increase for NIH.

—Balance the fiscal year 2007 NIH appropriation to allow growth across all NIH institutes and all areas of disease research.

We ask the subcommittee to be mindful of the thousands of Americans, and particularly those with MS, who will be affected if the pace of research is slowed by reductions in NIH funding. While treatments are available for MS, these are expensive and only partially effective for some patients. Until a cure is found, people affected by MS want more effective and more economical treatments.

The surest path to discovering treatments for MS, and for human diseases in general, is by sustaining the country's investment in innovative biomedical research at universities and small businesses. Funding cuts threaten these efforts, and will invariably harm the country's research infrastructure. Correcting such damage may take a generation, and Americans with MS cannot afford to wait that long. Moreover, the country cannot afford the economic consequences of delaying the discovery of treatments that could change the lives of those impacted by MS.

We thank the subcommittee for this opportunity to comment and applaud your commitment to advancing the health and well-being of all Americans through investment in biomedical research.

PREPARED STATEMENT OF THE NIH TASK FORCE OF THE BIOENGINEERING DIVISION OF THE BASIC ENGINEERING GROUP OF THE COUNCIL ON ENGINEERING OF ASME

The NIH Task Force of the Bioengineering Division of the Basic Engineering Group of the Council on Engineering of ASME, is pleased to provide comments on the bioengineering-related programs in the National Institutes of Health (NIH) fiscal year 2007 budget request. The ASME Bioengineering Division is focused on the application of mechanical engineering knowledge, skills and principles from conception to the design, development, analysis and operation of biomechanical systems.

THE IMPORTANCE OF BIOENGINEERING

Bioengineering is an interdisciplinary field that applies physical, chemical and mathematical sciences and engineering principles to the study of biology, medicine, behavior, and health. It advances knowledge from the molecular to the organ systems level, and develops new and novel biologics, materials processes, implants, devices, and informatics approaches for the prevention, diagnosis, and treatment of disease, for patient rehabilitation, and for improving health. Bioengineers have employed mechanical engineering principles in the development of many life-saving technologies, such as the artificial heart, prosthetic joints and numerous rehabilitation technologies.

BACKGROUND

NIH is the world's largest and most eminent organization dedicated to improving health through medical science. During the last 50 years, NIH has played a preeminent role in the major breakthroughs that have increased average life expectancy by 15 to 20 years.

NIH is comprised of different Institutes and Centers that support a wide spectrum of research activities including basic research, disease and treatments related studies, and epidemiological analyses. The missions of individual Institutes and Centers focus on a particular organ (e.g. heart, kidney, eye), on a given disease (e.g. cancer, infectious diseases, mental illness), on a stage of development (e.g. childhood, old age), or, may encompass crosscutting needs (e.g., sequencing of the human genome and the National Institute of Biomedical Imaging and Bioengineering (NIBIB).

The total fiscal year 2007 NIH budget request is $28.6 billion, which represents approximately the same level as the fiscal year 2006 appropriation. Some $50 million of this increase is for radiological/nuclear countermeasures development. NIH R&D, 97 percent of the total NIH budget, would also remain flat at $27.8 billion

next year. The largest increases would go to the Office of Director and towards biodefense R&D.

According to the President's fiscal year 2007 budget request, "NIH's highest priority is the funding of medical research through research project grants (RPGs). Support for RPGs allows NIH to sustain the scientific momentum of investigator-initiated research while pursuing new research opportunities." The administration estimates that the fiscal year 2007 budget would support an estimated 9,337 new research project grants (RPGs), an increase of about 275 new competing RPGs from fiscal year 2006. Nevertheless, NIH projects a decline in the total number of RPGs for the third year in a row, no inflation adjustment for most new or continuing grants, and a decline in the RPG success rate for the sixth year in a row down to 19 percent. RPGs account for 52 percent of the 2007 NIH Budget Request.

The largest percentage increase would go to the Office of the Director (OD; up 25.1 percent) to boost OD funding for clinical research, high-risk basic research, and collaborative research in the NIH Roadmap for Biomedical Research. The Roadmap would receive $443 million in fiscal year 2006 (up 34 percent), with $332 million coming from institute budgets. Currently, the Roadmap Initiatives provides $80 million annually, or roughly 24 percent of the total roadmap budget, for bioengineering-related project.

Other initiatives funded by the fiscal year 2007 budget request are 5 awards for the new K/R "Pathway to Independence" program and the Genes, Environmental, and Health Initiative (GEHI) that will study genetic factors associated with disease and accelerate technological development that can measure human responses to environmental influences on health.

The President's fiscal year 2007 budget requests $294.5 million for the NIBIB, a reduction of $1.96 million (0.7 percent) below the fiscal year 2006 enacted level. Most NIH institutes are also slated for reductions in funding in the President's budget request.

Below are some highlights from the fiscal year 2007 budget request for NIBIB. Further details can be found at http://www.nibib.nih.gov/publicPage.cfm?pageID=263#FY2007.

NIBIB Extramural Research would decline 1.3 percent, to $268 million.

The number of research project applications to NIBIB continues to grow, with the number doubling from fiscal year 2003 to fiscal year 2004 and then increasing by 20 percent from fiscal year 2004 to fiscal year 2005. The research budget, however, has remained flat. Consequently, the success rate for investigators applying for extramural research grants from the NIBIB is the second lowest among the NIH institutes and centers. It is estimated that the success rate for these applications was 16.8 percent in fiscal year 2004, decreasing to approximately 15 percent in fiscal year 2005. The projected success rate for fiscal year 2006 is only between 10 and 15 percent

NIBIB Intramural Research would grow 6.3 percent, to $7.7 million.

In September 2004, the NIBIB Special Advisory Panel for Intramural Programs met to develop recommendations for the National Advisory Council on Biomedical Imaging and Bioengineering concerning an intramural research program within the NIBIB. Intramural research accounts for approximately 10 percent of the total NIH budget. The NIBIB currently is at the low end in terms of funds it commits to intramural research among all of the NIH institutes, both in terms of dollars expended and percentage of its total budget. The Panel recommended that NIBIB not pursue the near-term expansion of its Intramural Research Program beyond the available funding in the current budget and the fiscal year 2005 President's Budget proposal. The Panel further recommended that NIBIB use its limited intramural funds primarily to expand interdisciplinary training opportunities at the postdoctoral level. In addition to the already established training grants offered by the NIBIB, there is a new initiative co-sponsored by the NSF Engineering Directorate to offer summer institute training for undergraduate students. It is hoped that such programs can be offered regularly now and/or expanded. More information can be found at http://bbsi.eeicom.com/.

The estimate for NIH-wide bioengineering research was $1.291 billion in fiscal year 2006, and $1.32 billion in fiscal year 2005. The proposed 2007 amount is $1.296 billion, a 0.4 percent increase over 2006. These numbers reflect bioengineering funding by any of the 27 NIH institutes or Office of the Director.

RECOMMENDATIONS

The Task Force is concerned that funding for bioengineering has continued to lag compared to many areas of NIH, and will continue to do so, especially now that the

doubling of the NIH budget is complete and the total funding for NIH remains flat. While a strong supporter of the NIBIB, the Task Force is also concerned that bioengineering continues to constitute less than half the budget for the NIBIB. There is a need for advanced engineering concepts to be applied to basic and translational biomedical problems for the potential of recent biological advances to be realized. The request for more bioengineering funding addresses a critical need for developing and applying more complex engineering principles to biomedical problems. In many cases, such engineered solutions to health care problems will result in a reduction in health care costs. Therefore, the Task Force strongly urges Congress to provide increased funding for bioengineering within the NIBIB and across NIH. The NIBIB requires exceptional consideration for funding increases in the coming years. It is notable that the success rate for funding applications to the NIBIB is currently between 10–15 percent, even lower than the declining average NIH-wide success rate of 19 percent. This is a direct manifestation of the continued growth of the field outpacing funding increases to the NIBIB.

While the Task Force supports new Federal proposals that seek to double Federal research and development in the physical sciences over the next decade, the Task Force believes that strong Federal support for bioengineering and the life sciences is essential to the health and competitiveness of the Nation. Increased funding for the NIH has put the United States is a leading position in pharmaceuticals, bioengineering, and medical sciences. Long-term lack of funding for NIH programs would harm the tremendous gains the United States has made over the last decade.

ASME International is a non-profit technical and educational organization with 125,000 members worldwide. The Society's members work in all sectors of the economy, including industry, academic, and government. This statement represents the views of the ASME NIH Task Force of the Bioengineering Division and is not necessarily a position of ASME as a whole.

PREPARED STATEMENT OF THE NATIONAL PRIMATE RESEARCH CENTERS

The Directors of the National Primate Research Centers (NPRCs) respectfully submit this written testimony for the record of the U.S. Senate Appropriations Subcommittee on Labor, Health and Human Services, and Education. The NPRCs appreciate the commitment that the members of this subcommittee have made to biomedical research through strong support for the National Institutes of Health (NIH). Given your leadership on this issue, the NPRCs urge Congress to direct resources to NIH to ensure that the Federal investment in vital biomedical research will not be compromised.

The NPRCs are a national network of eight primate research centers supported by the NIH National Center for Research Resources (NCRR). The centers comprise the National Primate Research Program (NPRP), which was developed by Congress in 1960. The program seeks to address human health problems through scientific research using the animal models that most closely resemble humans in their genetics, physiology, and disease processes—primates. NPRCs support research that is sponsored by nearly every institute of NIH. For example, NPRCs conduct research to help understand and treat diseases such as heart disease, hypertension, cancer, diabetes, hepatitis, AIDS, kidney disease, Alzheimer's disease, and Parkinson's disease. They also conduct research on emerging infectious diseases and many aspects of biodefense. Each NPRC makes its facilities available to investigators from around the country. Our centers create collaborative research environments that allow scientists to combine their individual expertise beyond the scope of established disciplinary research projects.

NPRCs endorse the fiscal year 2007 Ad Hoc Group for Medical Research proposal to increase the NIH budget by five percent over the fiscal year 2006 level. We recognize that the current budget environment puts pressure on Congress to face difficult funding trade-offs; however, as this subcommittee works to define priorities for the year and set goals for the future, we ask that you maintain your long-term commitment of support for NIH and its mission. The President's fiscal year 2007 budget would flat-fund NIH. The five percent increase for NIH supported by NPRCs would not only allow the agency to sustain current programs but also invest in critical new initiatives. This would prevent NIH from falling behind the "Innovation Index"—the rate of biomedical inflation as calculated in the Biomedical Research and Development Price Index (BRDPI) plus a modest investment in new initiatives. Using the fiscal year 2007 BRDPI projection as a base, NIH would require an increase of at least 3.8 percent over fiscal year 2006 to maintain current programs. However, we strongly believe that an increase for NIH above BRDPI is justified by the health needs as well as current and burgeoning research capabilities of the Nation. An in-

crease above BRDPI would allow new innovative ideas to be funded and would infuse existing programs to evolve as their research findings push them to higher levels of basic understanding, translation and clinical functionality.

As a result of years of expanded investment in biomedical research, the demand for the NPRCs' resources has increased significantly. The ability of NIH-funded researchers to conduct future projects with primate models will depend on the enhancement of three key areas: (1) the nationwide availability of primates; (2) the quality and capacity of primate housing and breeding facilities, as well as the availability of related state-of-the-art diagnostic and clinical support equipment at NPRCs; and (3) the number of personnel trained in primate care and management at NPRCs. These areas can be enhanced by an NIH/NCRR commitment to increase the NPRCs P51 base grants (the mechanism that funds each NPRC). Biomedical researchers across the Nation are experiencing shortages in the availability of primates for essential research. Increases to the P51 base grants would allow NPRCs to: expand existing breeding colonies and develop bridging programs to use effectively the under-utilized species of primates in research; invest in repairs, renovation, and construction of research facilities, as well as the purchase of modern laboratory equipment; and ensure that adequate numbers of experts are trained in laboratory animal medicine and research, because NPRCs must maintain primate management teams comprised of behavioral specialists, veterinarians, and primate research experts to ensure excellent primate care, health, and research success.

Increases from NIH/NCRR to the NPRCs P51 base grant are necessary to meet the needs discussed above and are critical to the ability of NPRCs to supply adequate primate resources for scientists across the Nation to carry out important research projects. As mentioned previously, these research projects span the disease foci at NIH institutes and centers, and also play important roles in the NIH Roadmap, the NCRR Strategic Plan, and grand challenges facing the scientific community. In the 1950's, primate research produced the first vaccine for one of the world's worst childhood killers, the Polio virus, reducing the number of cases in the United States from 58,000 to one or two per year. Primates have also served as the best model for various types of HIV research, and their availability for use has resulted in at least 14 licensed anti-viral drugs for treatment of HIV infection. Primate models will continue to be necessary to defend the world against possible future epidemics such as SARS, West Nile Virus, and avian flu. In addition to deadly viral epidemics, primate research has enabled the discovery of better treatments and therapies for diseases and occurrences such as stroke, cataracts, depression and other psychiatric illnesses. Significant advances in prenatal and postnatal care have also resulted from primate research.

Further, not only do primates have the potential to provide answers for longstanding research questions, primate research provides an unparalleled opportunity to address more recently defined research priorities, such as those relating to genomics and bioterrorism. The specific availability of information in the primate genome, which is quite similar to the human genome, makes primates essential in studies that require an integrated understanding of a whole biological system. Recent reports suggest that extensive analysis of genome structure and function in nonhuman primates could make immediate and significant contributions to the overall mission of NIH by accelerating progress in understanding many human diseases. Also, primates serve as critical animal models in biodefense research projects for which, in some cases, it would be inappropriate to conduct early clinical trials in humans. Primates are recognized as vital research resources within Federal strategic plans regarding biodefense research, including: the National Institute of Allergy and Infectious Diseases (NIAID) Strategic Plan for Biodefense Research; the NIAID Research Agenda for Category A Agents; and the NIAID Research Agenda for Category B and C Priority Pathogens. Also, NPRCs are partners in NIAID-funded Regional Centers of Excellence for Biodefense and Emerging Infectious Diseases as well as with NIAID-funded National and Regional Biocontainment Laboratories.

As NIH and the national biomedical research agenda evolve, NPRCs adjust to meet the resource needs of the research community but also to maintain research programs that are on the cutting-edge of science. The reservoirs of knowledge residing within the NPRCs create new opportunities for research partnerships with investigators at host academic institutions and in the biomedical research community at large. Never have the research questions been so profound, or the implications for human health so critical. NPRCs are poised to bridge the gap between knowledge already gleaned from simple cellular and animal models and knowledge that is needed to promote human health and cure human disease. Past accomplishments demonstrate, and current and future research directions will rely on, the roles of robust primate research programs in addressing critical research questions. The

breadth and success of primate research programs confirm the vital role that the eight NPRCs play in biomedical research nationwide.

Thank you for the opportunity to submit this written testimony and for your attention to the critical need for primate research and enhancement of the NPRCs P51 base grant, as well as our recommendations concerning funding for NIH in the fiscal year 2007 Appropriations Bill.

PREPARED STATEMENT OF THE NATIONAL PROSTATE CANCER COALITION

On behalf of the National Prostate Cancer Coalition, I appreciate the opportunity to submit written comments regarding funding to Prostate Cancer programs. I would also like to offer our best estimates on the resources necessary to continue to fight the war on prostate cancer in fiscal year 2007, most specifically funding for prostate cancer research, prevention, detection and treatment programs funded by the Labor, Health and Human Services and Education Appropriations Bill.

HISTORY OF PROSTATE CANCER FUNDING

For the past ten years, the NPCC has worked to reduce the burden of prostate cancer through awareness, outreach, and advocacy. As you may know Prostate cancer is the most common cancer (next to skin cancer) and the second leading cause of cancer-related death in men in the United States. It is estimated this year over 234,000 men will be diagnosed with prostate cancer, and more than 27,000 will die as a result of the disease. Of the 10 million Americans living with cancer today, two million of these have prostate cancer.

This past decade has been an exciting and important one for prostate cancer research. Congress and the administration have taken notice of the impact prostate cancer has on our Nation. In 1998, Congress promised to double the budget of the NIH within 5 years, and triple the amount of Federal funding for prostate cancer research. By keeping that promise, prostate cancer research funding has increased and expanded to record levels. As a result, more men are screened and diagnosed with this disease and prostate cancer survivorship rates have increased. Also for the first time since 1930, the number of cancer deaths has decreased in 2003. These exciting results cannot continue without a stable and reasonable level of funding to the NIH. Unfortunately in fiscal year 2003, NIH funding did not keep up with the increase of inflation. Last year in fiscal year 2006 the NIH and prostate cancer research programs received a hard cut to programs at the Center for Disease Control and the National Cancer Institute.

With less funding, researches cannot continue to discover ways to combat prostate cancer. New drugs and treatment options are harder to translate from the lab to the patients. We cannot fight the war on prostate cancer without the proper tools. The National Prostate Cancer Coalition understands the limited resources our Nation faces. However, when research continues to show the eradication of cancer is within research, we must continue to fund these programs which will save millions of lives, reduce untold suffering and save the Nation billions of dollars in healthcare costs.

It is important to note that Americans spend over $4.6 billion per year for treatment of this disease (this does not include the burden of lost productivity and wages). Statistics show that as baby boomers continue to age, the number of Americans impacted by cancer will increase. These statistics show the far reaching effects prostate cancer can have, not only on individuals and their families, but the Nation's economy as well.

FUNDING REQUESTS

This year we have joined with the Cancer and Public Health Communities to urge this committee and Congress to provide $29.7 billion for the NIH, a $1.4 billion increase of fiscal year 2006. We request funding that will maintain current programs and progress at the NIH. We would also request that Congress appropriate $5.034 billion for the National Cancer Institute, a $240 million increase over fiscal year 2006. Again, this funding would only maintain the current discovery pace. Additionally we ask for Congress to appropriate $20 million (+6.07 million) for the Prostate Cancer Control Initiatives at the Centers for Disease Control. With this program, the public receives information about prostate screening and early detection. With increased funding, this program can expand and improve outreach efforts.

The NPCC urges these changes to the fiscal year 2007 Appropriations bill to ensure funding to cancer research and related programs are a top priority in fiscal year 2007 and in the future. We thank you for the opportunity to discuss the need

for these tools to fight the war on prostate cancer. Again, we need to continue to fund these programs to ensure that our Nation continues to make advances in cancer eradication.

PREPARED STATEMENT OF THE NATIONAL SLEEP FOUNDATION

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS

—Provide a 5 percent increase for fiscal year 2007 to the National Institutes of Health (NIH) and a proportional increase of 5 percent to the individual institutes and centers, specifically, the National Heart, Lung, and Blood Institute (NHLBI).
—Continue to urge the National Center on Sleep Disorders Research (NCSDR) of the NHLBI and the Centers for Disease Control and Prevention (CDC) to partner with voluntary health organizations, such as the National Sleep Foundation (NSF), to develop a collaborative sleep education and public awareness initiative based on the roundtable model that other public health-related agencies have used with success. In view of the success of the CDC with similar initiatives, encourage and support the CDC in taking a leadership role with the roundtable initiative.
—Encourage the Director of the NIH and the Director of the National Heart, Lung, and Blood Institute to name a permanent Director to the National Center on Sleep Disorders Research.
—Encourage CDC to increase support for initiatives connecting sleep to overall health and safety. Provide $6.321 billion for fiscal year 2007 to the CDC, the same amount Congress provided to the agency in fiscal year 2005.
—Continue to urge the United States Surgeon General to develop and implement a report on sleep and sleep disorders in order to call attention to the importance of sleep and develop strategies to protect and advance the health and safety of the Nation.

Mr. Chairman and members of the subcommittee, thank you for allowing me to submit testimony on behalf of the National Sleep Foundation (NSF). I am Dr. Barbara Phillips, Chairman of the NSF Board of Directors and professor at the University Of Kentucky College Of Health in the Department of Preventive Medicine. The NSF is an independent, non-profit organization that is dedicated to improving public health and safety by achieving understanding of sleep and sleep disorders, and by supporting sleep-related education, research, and advocacy. We work with sleep medicine and other health care professionals, researchers, patients and drowsy driving victims throughout the country as well as collaborate with many government and public and private organizations with the goal of preventing health and safety problems related to sleep deprivation and untreated sleep disorders.

Sleep problems, whether in the form of medical disorders, or related to work schedules and a 24/7 lifestyle, are ubiquitous in our society. At least 50 million Americans suffer from sleep disorders and millions of others experience sleep problems related to other medical conditions; yet more than 60 percent of adults have never been asked about the quality of their sleep by a physician, and fewer than 20 percent have ever initiated such a discussion. Millions of individuals struggle to stay alert at school, on the job, and on the road. According to the National Highway Traffic Safety Administration's 2002 National Survey of Distracted and Drowsy Driving Attitudes and Behaviors, an estimated 1.35 million drivers have been involved in a drowsy driving related crash in the past five years. A large number of academic studies have linked work accidents, absenteeism, and school performance to sleep deprivation and circadian effects.

Sleep apnea, a sleep-related breathing disorder which affects at least 5 percent of adult Americans and is closely related to some of America's most pressing health problems, such as obesity, hypertension, heart failure, and diabetes. Chronic insomnia, experienced by at least 10 percent of our population is a strong risk factor for depression and other widespread mental health conditions. The direct and indirect costs associated with sleep disorders and sleep deprivation total an estimated $100 billion annually.

Sleep science has clearly demonstrated the importance of sleep to health and well-being, yet research studies continue to show that millions of Americans are at risk for the serious health and safety consequences of untreated sleep disorders and inadequate sleep. Moreover their quality of life suffers and the personal and national economic impact is staggering. The severity of the public health burden represented by sleep issues are compellingly detailed in a groundbreaking new report, Sleep Dis-

orders and Sleep Deprivation: An Unmet Public Health Problem by the Institute of Medicine.

NSF believes that every American needs to understand that good health includes healthy sleep, just as it includes regular exercise and balanced nutrition. We must elevate sleep to the top of the national health agenda. We need your help to make this happen.

Our biggest challenge is bridging the gap between the outstanding scientific advances we have seen in recent years and the level of knowledge about sleep held by health care practitioners, educators, employers, and the general public. Consequently, the NSF is spearheading two important initiatives to raise public and physician awareness of the importance of sleep to the health, safety and well-being of the Nation.

First, because resources are limited and the challenges great, we think creative and new partnerships need to be developed to address sleep awareness. Therefore, the NSF has been working with the National Center on Sleep Disorders Research (NCSDR) and the Centers for Disease Control and Prevention (CDC), to develop an ongoing, inclusive mechanism for public and professional awareness on sleep, sleep disorders and the consequences of fatigue. Such collaboration between Federal agencies and voluntary health organizations would create an opportunity for dramatically improving public health and safety as well as the quality of life for millions, if not all, Americans. Since November of 2004, NIH, CDC, and NSF have been meeting with other interested and diverse voluntary and professional groups and Federal agencies to discuss the formation of a broad coalition dedicated to raising public awareness of sleep. This effort should continue to receive the support of Congress in order to encourage the participation of relevant Federal agencies.

In relation to this effort, the National Center on Sleep Disorders Research within the National Heart, Lung and Blood Institute (NHLBI) currently has an acting director as the result of the recent promotion of Dr. Carl Hunt. NCSDR was created in 1993 by the National Institutes of Health Revitalization Act (Public Law 103–43) and has served an important role in furthering the scientific and public health knowledge related to sleep deprivation and sleep disorders. NSF requests that you encourage both Drs. Elias Zerhouni, the Director of NIH, and Elizabeth Nabel, the Director of the NHLBI to name a permanent director to this vitally important Center as soon as possible, so that the mission of the NCSDR is not significantly impacted. Additionally, given the significant and unique mission of the Center, NIH should consider the following characteristics for the NCSDR director position: history of collaborative efforts among sleep investigators and educators; recognition and stature in the field of sleep medicine; and familiarity with the research needs and gaps in the field of sleep medicine.

Secondly, at the National Institutes of Health's Frontiers of Knowledge in Sleep and Sleep Disorders conference, the U.S. Surgeon General acknowledged widespread illiteracy in our country regarding sleep loss and untreated sleep disorders. He emphasized that sleep problems are easily related to the three top areas of the national health agenda: prevention, preparedness, and health disparities. Prevention of some of our Nation's most pressing health problems would be fostered by attending to sleep disorders. Sleep deprivation is a major barrier to maximizing preparedness and response in times of crisis. Finally, like many health concerns, access to knowledge and medical care for sleep problems is less accessible to some of our citizens.

Conferences and workshops held by the Surgeon General involve educating the public, advocating for effective disease prevention and health promotion programs and activities, and providing a highly recognized symbol of national commitment to protecting and improving the public's health. The NSF believes it is time that the Federal Government helps promote sleep as a public health concern through the development of a Surgeon General's Report on Sleep and Sleep Disorders in order to call attention to the importance of sleep and develop strategies to protect and advance the health and safety of the Nation. Therefore, the NSF is advocating for the development and dissemination of a Surgeon General's Report on Sleep and Sleep Disorders.

The new report by the Institute of Medicine includes important recommendations that support the sprit of these efforts and other specific actions to be taken by the CDC, NIH and other Federal agencies and private foundations to increase surveillance of and education on sleep health and sleep disorders. CDC, NIH and the Surgeon General must partner with voluntary health organizations and increase support for initiatives that help ensure the health and safety of all Americans.

Thank you again for the opportunity to present you with this testimony.

PREPARED STATEMENT OF THE NEPHCURE FOUNDATION

SUMMARY OF RECOMMENDATIONS FOR FISCAL YEAR 2007

(1) A 5 percent increase for the National Institutes of Health (NIH) and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

(2) Continue to expand the NIH'S Nephrotic Syndrome (NS) and Focal Segmental Glomerularsclerosis (FSGS) research portfolios by aggressively supporting NIDDK grant proposals in this area and by encouraging the National Center for Minority Health and Health Disparities (NCMHD) to initiate studies into the incidence and cause of NS and FSGS in minority populations.

Mr. Chairman and members of the subcommittee, I am pleased to present testimony on behalf of the NephCure Foundation (NCF), a non-profit organization driven by a panel of respected medical experts and a dedicated band of patients and families working together towards a common goal-to save kidneys and to save lives. NCF is the only non-profit organization exclusively devoted to fighting idiopathic nephrotic syndrome (NS) and focal segmental glomerulosclerosis (FSGS). Now in its sixth year, the NephCure Foundation continues to work tirelessly to support glomerular disease research.

FSGS: One Family's Story

My son, Bradly Grizzard, was diagnosed with focal segmental glomerulosclerosis (FSGS) in 2002. In May of 2005, I donated one of my kidneys to him.

FSGS is one of a cluster of glomerular diseases that attack the one million tiny filtering units (nephrons) contained in each human kidney. Glomerular disease attacks the portion of the nephron called the glomerulus, scarring and often destroying these filters. Scientists do not know why glomerular injury occurs, and there is no known cure for these diseases.

FSGS patients, upon diagnosis, often take a downward plunge at a rapid rate and it is extremely difficult to make a comeback. My son was a star football player at his high school and was being recruited by college football coaches before FSGS attacked his body. When his kidneys failed, he was forced to give up football, and he had to try and juggle college classes along with several hours of dialysis a day. We were lucky that my kidney was a match for him, but even so the first few hospitals that we approached refused to perform the transplant. We were eventually able to find a doctor and a hospital that was willing to perform the operation, and the transplanted kidney is now working well. But Bradly must remain on costly immunosuppressant drugs for the rest of his life. These drugs cause many unpleasant side effects and medical complications.

My son's story is not unique. There are thousands of other people in this country who have had their lives disrupted due to the sudden onset of FSGS or NS. And although kidney transplants have been very successful for thousands of patients, many patients end up rejecting the transplanted kidney. Other times, the disease comes back and attacks the transplanted kidney. In either case, the patient must then again rely on daily dialysis as a means of survival. There are thousands of young people who are in a race against time, hoping for a treatment that will save their lives. The NephCure Foundation today raises its voice to speak for them all, asking you to take specific actions that will aid our quest to find the cause and cure of FSGS and NS.

First and foremost, we join the Ad Hoc Group for Medical Research Funding in asking for a 5 percent increase for the National Institutes of Health (NIH) and the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK).

More Research is Needed

We are no closer to finding the cause or the cure of FSGS. Scientists tell us that much more research needs to be done on the basic science behind the disease.

We are thankful that the NIDDK continues to work with the NephCure Foundation on the FSGS clinical trial. Currently 150–175 patients nationwide are enrolled in the trial. Recently, the steering committee charged with providing programmatic direction to the trial decided on several changes which would accelerate progress. NCF is also working with the NIDDK to cosponsor ancillary basic biological material studies of the enrolled patients.

The NephCure Foundation is also grateful to the NIDDK for issuing two program announcements (PAs) that serve to initiate grant proposals on glomerular disease. The first program announcement, issued in December of 2005, includes glomerular disease as one of several kidney or urologic diseases for which the PA will fund grant proposals. The second PA, issued in March of 2006, is glomerular-disease specific. Both of these announcements will utilize the R21 mechanism to award researchers $275,000 over two years.

We ask the Committee to encourage the NIDDK to help find the cause and the cure for glomerular disease by continuing its support for the FSGS clinical trial and the ancillary basic biological material studies. We also ask the NIDDK to continue to add glomerular disease to program announcements.

Too Little Education About a Growing Problem

When glomerular disease strikes, it results in a loss of protein from the urine and edema. The edema often manifests itself as puffy eyelids, a symptom that many parents and physicians mistake as allergies. With experts projecting a substantial increase in the number of cases of glomerular disease in the coming years, there is a clear need to educate pediatricians and family physicians about glomerular disease and its symptoms.

The NephCure Foundation has numerous education programs underway. A national FSGS conference will be held in Philadelphia from June 3rd–4th, 2006. This conference will aim to provide attendees with the most up to date information on this disease. Through speakers, information sessions, and informal conversations with other patient families, attendees will realize they are not alone and will be further energized for the effort to find a cause and a cure for FSGS.

Also, this summer, the NIDDK will sponsor a working group scientific conference. This working group will advise NIDDK on animal models, reagents, and other resources for the study of glomerular disease.

We also applaud the work of the NIDDK in establishing the National Kidney Disease Education Program (NKDEP), and we seek your support in urging the NIDDK to make sure that glomerular disease remains a focus of the NKDEP.

We ask the Committee to encourage the NIDDK to have glomerular disease receive high visibility in its education and outreach efforts, and to continue these efforts in conjunction with the NephCure Foundation's work. These efforts should be targeted towards both physicians and patients.

Glomerular Disease Strikes Minority Populations

Nephrologists tell us that glomerular disease strikes a disproportionate number of African-Americans. No one knows why this is, but some studies have suggested that a genetic sensitivity to sodium may be partly responsible. DNA studies of African Americans who suffer from FSGS may lead to insights that would benefit the thousands of African Americans who suffer from kidney disease.

As an African-American female and the mother of a son with FSGS, I ask that the NIH pay special attention to why this disease affects my race to such a large degree. The NephCure Foundation wishes to work with the NIDDK and the National Center for Minority Health and Health Disparities (NCMHD) to encourage the creation of programs to study the high incidence of glomerular disease within the African-American population.

There is also evidence to suggest that the incidence of glomerular disease is higher among Hispanic-Americans than in the general population. An article in the February 2006 edition of the NIDDK publication Recent Advances and Emerging Opportunities, discussed the case of Frankie Cervantes, a six year old boy of Mexican and Panamanian descent. Frankie has FSGS, and like Bradly, received a transplanted kidney from his mother. We applaud the NIDDK for highlighting FSGS in their publication, and for translating the article about Frankie into both English and Spanish. Only through similar culturally appropriate efforts can African American and Hispanic families learn more about glomerular disease.

We ask the Committee to join with us in urging the NIDDK and the National Center for Minority Health and Health Disparities (NCMHD) to collaborate on research that studies the incidence and cause of this disease among minority populations. We also ask that the NIDDK and the NCMHD undertake culturally appropriate efforts aimed at educating minority populations about glomerular disease.

PREPARED STATEMENT OF ONE VOICE AGAINST CANCER

One Voice Against Cancer (OVAC) appreciates the opportunity to submit written comments for the record regarding funding for cancer programs for research, prevention, detection, and treatment as well as programs that educate and train nurses in fiscal year 2007 at the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration (HRSA). OVAC is a collaboration of more than 40 major national organizations representing millions of Americans affected by cancer, unified to urge Congress and the White House to increase cancer-related appropriations. OVAC stands ready to work with policymakers at the Federal, State, and local levels to ensure

that these important cancer and nursing initiatives at NIH, CDC, and HRSA receive adequate funding in fiscal year 2007.

Our Nation's prior investments in cancer research-related programs have saved thousands of lives and accelerated our progress toward the Administration's goal of eliminating death and suffering due to cancer by the year 2015. However, the challenge remains—cancer will strike one of every two men and one of every three women in the United States. This year alone, more than 1.4 million men and women in this country will receive the devastating news that they have cancer; yet, more than 10 million cancer survivors can attest to the fact that we are making real progress against this disease.

The Congress took a bold step forward in 1998 when it promised to double the budget of the National Institutes of Health (NIH) within five years. By keeping that promise, Congress opened the floodgates to countless new opportunities and advances in cancer research and programs. Thanks to the advances spawned by that infusion of support for biomedical research, cancer survivorship rates have steadily increased each year. For the first time since 1930, the number of cancer deaths in the United States decreased in 2003. Congress must maintain that promise with a stable and reasonable level of funding increases to sustain the momentum of this exciting research. Since fiscal year 2003, NIH funding levels have fallen far short of keeping pace with inflation alone, and fiscal year 2006 resulted in a hard cut to both NIH and National Cancer Institute funding levels.

Less funding translates immediately into fewer discoveries, fewer new drugs in development, and fewer new treatments reaching patients. We cannot reach the 2015 goal without the continued support of the Congress. We appreciate that our Nation faces many challenges and Congress has limited resources to allocate. However, the conquest of cancer and elimination of health disparities is truly within our grasp. Making cancer a national priority will save millions of lives, reduce untold suffering, and save the Nation billions of dollars in healthcare costs now and for the foreseeable future. The investment is surely worth it.

SUSTAIN AND SEIZE CANCER RESEARCH OPPORTUNITIES

The tremendous investment our Nation has made in the National Institutes of Health (NIH) has reaped remarkable returns and set the table for a period of unparalleled innovation in the fight against cancer and other diseases. For fiscal year 2007, OVAC joins with the broader public health community and urges Congress to provide $29.7 billion for the NIH, a $1.4 billion increase over fiscal year 2006. This is the minimal level of funding that will allow the NIH to maintain the current pace of discovery and innovation.

OVAC recognizes the fiscal challenges facing policymakers, but does not believe that those challenges require us to weaken our national commitment to conquering cancer. While the long-term goal of providing adequate funding to explore the most promising opportunities must remain paramount, for fiscal year 2007, OVAC urges Congress to provide the National Cancer Institute (NCI) with at least $5.034 billion, a $240 million increase over fiscal year 2006. This level of funding is the bare minimum required to protect our cancer research enterprise and maintain the current pace of discovery.

While a minimal increase of $240 million will maintain current programs, it is not sufficient to allow us to move forward with advances that we know are possible. For fiscal year 2007, OVAC would recommend an increase closer to that of the professional judgment budget prepared by the NCI Director. This budget, which calls for $5.9 billion for fiscal year 2007, represents our national battle plan against cancer, outlining the critical core research that is currently underway and the most promising and extraordinary research opportunities. These exceptional research opportunities include expansion of the NCI-designated cancer centers program from 60 to 75 centers; implementation of the plan to reengineer cancer clinical trials for greater standardization, speed, and efficiency; construction of linkages between science and the new technologies of advanced imaging, proteomics, and computational modeling; expansion of the use of medical informatics and bioinformatics to cancer-specific applications; and development of an integrative site-based approach to cancer research through interdisciplinary team science and collaboration. The professional judgment budget is developed through an open and public process; it reflects the best thinking of cancer researchers, patients, clinicians, and other constituency groups and is focused on the Institute's goal of eliminating suffering and death from cancer by the year 2015.

The National Center on Minority Health and Health Disparities (NCMHD) was created by Congress to help address the undue burden of chronic and acute disease, morbidity and mortality, and lower survival rates borne by racial and ethnic minor-

ity groups, rural populations and other medically underserved populations. OVAC urges the Congress to provide the NCMHD with $200 million for fiscal year 2007 to advance its critical work coordinating and advancing health disparities research across the NIH. OVAC seeks to ensure that NCMHD has the resources to develop and enhance initiatives aimed at reducing and ultimately eliminating disparities in many chronic diseases, including cancer. Having worked with Congress to establish the NCMHD, the members of OVAC are committed to seeing it fulfill its mission and achieve its goals and objectives.

BOOST OUR NATION'S INVESTMENT IN CANCER PREVENTION, EARLY DETECTION, AND AWARENESS

The Centers for Disease Control and Prevention's (CDC) State-based cancer programs provide vital resources for cancer monitoring and surveillance, breast and cervical cancer screening, State cancer control planning and implementation, and awareness initiatives targeting skin, prostate, colon, ovarian and blood cancers. For fiscal year 2007, OVAC requests the following funding levels for these proven programs:

—*National Comprehensive Cancer Control Program: $50 million (+$33 million).*—The Comprehensive Cancer Control program provides grants and technical assistance to help States develop and implement plans addressing the cancers most significantly affecting their communities through prevention, early detection and treatment. OVAC's request will allow this program to help more States implement previously developed plans.

—*National Program of Cancer Registries: $65 million (+$16.89 million).*—The National Program of Cancer Registries facilitates State tracking of cancer trends and subsequent allocation of resources to address specific needs, while also identifying highly effective cancer control programs that can be emulated across the country. The registry provides critical data to ensure we remain on track in the fight against cancer. OVAC's request will enable States to continue to collect and analyze high-quality data as well as evaluate existing cancer prevention efforts.

—*National Breast and Cervical Cancer Early Detection Program: $250 million (+$47.57 million).*—OVAC appreciates the Administration's longstanding commitment to this important program that provides free breast and cervical screening tests to low income and uninsured women. Unfortunately, millions of eligible women lack access to these critical tests due to lack of funding. The CDC estimates that the program currently only reaches 20 percent of eligible women aged 50 to 64. OVAC's funding request for fiscal year 2007 would allow at least an additional 130,000 women to be served by the program.

—*Colorectal Cancer Screening, Education & Outreach Initiative: $25 million (+$10.51 million).*—Strong scientific evidence has shown that regular screening and treatment is a cost-effective way to reduce colorectal cancer incidence and mortality. However, screening rates for CRC are currently lower than for other cancer screening services. The Colorectal Cancer Screening, Education & Outreach Initiative helps increase public awareness of colorectal cancer, educate health care providers about colorectal screening guidelines and assist State programs with colorectal cancer priorities. With additional resources this program will be able to expand its awareness initiatives and reduce the number of preventable colorectal cancer deaths.

—*National Skin Cancer Prevention Education Program: $5 million (+$2.93 million).*—Skin cancer is the most common form of cancer in the United States and is largely preventable. OVAC's request will allow the program to educate the public about ways to protect themselves and reduce the risks of getting skin cancer.

—*Prostate Cancer Control Initiatives: $20 million (+6.07 million).*—This initiative provides the public, with special emphasis on men and their physicians, with information about prostate cancer screening and early detection. OVAC's request will allow the program to expand and improve its outreach efforts.

—*Ovarian Cancer Control Initiatives: $7.5 million (+$2.98 million).*—The Ovarian Cancer Initiative partners with academic and medical institutions to spur discovery of techniques that will detect this cancer and develop more successful treatments. OVAC's request will increase public and professional awareness of the symptoms and best treatments for ovarian cancer, restoring hope to the more than 20,000 women who will be diagnosed with this devastating illness this year.

—*Geraldine Ferraro Blood Cancer Program: $5 million (+$0.46 million).*—Authorized under the Hematological Cancer Research Investment and Education

Act of 2002, this program was created to provide public and patient education about blood cancers, including leukemia, lymphoma and myeloma. OVAC's request will allow the program to continue to provide patients with educational, disease management and survivorship resources to enhance treatment and prognosis.

SECURING AND MAINTAINING AN ADEQUATE ONCOLOGY NURSING WORKFORCE

OVAC joins with the nursing community in asking Congress to provide $175 million in fiscal year 2007 for the Nurse Reinvestment Act and the other nursing workforce programs at the Health Resources and Services Administration (HRSA). Over the next 15 years, the number of Medicare beneficiaries with cancer is expected to double, while more than 1.1 million nursing positions go unfilled. The critical role of nurses in our health care system cannot be overstated. Oncology nurses are on the front-lines of the provision of quality care for cancer patients and are vital to administering chemotherapy, managing patient treatments and side-effects and providing counseling to patients and family members.

Without an adequate supply of nurses, there will not be enough qualified oncology nurses to provide quality, comprehensive cancer care to a growing patient population in need. Nurses are also vital to helping conduct cancer research through clinical trials, and a shortage will slow down the pace of medical research progress. These programs will help address the multiple factors contributing to the nationwide nursing shortage, including the decline in student enrollments, shortage of faculty and poor public perception of nursing as a viable and worthwhile profession.

CONCLUSION

OVAC stands ready to work with policymakers to ensure that funding for cancer research and related programs is a top priority in fiscal year 2007 and beyond. We thank you for this opportunity to discuss the funding levels necessary to ensure that our Nation continues to make gains in our fight against cancer and has a sufficient nursing workforce to care for the patients with cancer of today and tomorrow.

PREPARED STATEMENT OF THE OVARIAN CANCER NATIONAL ALLIANCE

On behalf of the Ovarian Cancer National Alliance (the Alliance), I thank the subcommittee for this opportunity to submit written testimony regarding the fiscal year 2007 funding allocations for programs in the Labor-Health and Human Services and Education appropriations measure that the Alliance and ovarian cancer community believe are necessary to help reduce and prevent suffering from ovarian cancer. Since its inception nine years ago, the Alliance has worked to increase awareness of ovarian cancer and boost Federal resources to support scientific research into diagnostics and treatments for the disease. Among the most urgent challenges in the ovarian cancer field are late detection and poor survival of women.

As a national umbrella organization with 50 regional, State, and local groups, the Alliance unites and reaches more than 800,000 grassroots activists, women's health advocates, health care professionals and the public to bring national attention to ovarian cancer. As part of this effort, the Alliance advocates for a sustained Federal investment in ovarian cancer research, awareness, education and early detection. To that end, the Alliance respectfully requests that the subcommittee provide the following in fiscal year 2007 funding:

—$7.5 million to the Centers for Disease Control and Prevention's (CDC) Ovarian Cancer Control Initiative;

—$29.7 billion to the National Institutes of Health (NIH); and

—$5.034 billion to the National Cancer Institute (NCI).

These three agencies are working relentlessly to achieve much-needed gains in ovarian cancer early detection, treatment and survivorship. Consistent investment in ovarian cancer research and public awareness campaigns at CDC, NIH and NCI is vital to our fight against this deadly disease. The Alliance believes all women should have the opportunity to survive ovarian cancer, but unfortunately, unless our Nation makes significant investment in ovarian cancer research and awareness efforts, thousands of women will continue to lose their lives every year.

OVARIAN CANCER'S DEADLY STATISTICS

Today, it is both striking and disheartening to see that despite progress made in the scientific, medical and advocacy communities, ovarian cancer mortality rates have not significantly improved during the past decade. According to the American Cancer Society, in 2006 more than 20,000 American women will be diagnosed with

ovarian cancer and approximately 15,300 will lose their lives to this disease, making it the fifth leading cause of cancer death in women (behind lung, breast and colorectal cancers). Every woman is at risk for ovarian cancer and one in 58 will develop it in her lifetime.

Behind the sobering statistics are the lost lives of our loved ones, colleagues and community members. The country recently lost a national treasure to the disease when Mrs. Coretta Scott King died from stage III ovarian cancer in January. Her disease was considered terminal after a late-stage diagnosis. Unfortunately, Mrs. King's story is common for women in our community. When detected early, the five-year survival rate for women with ovarian cancer increases to more than 90 percent. However, a valid and reliable screening test—a critical tool for improving early diagnosis and survival rates—still does not exist for ovarian cancer. With no early detection test, more than 75 percent of women diagnosed with ovarian cancer are diagnosed in stage III or IV. At these stages prognosis is worst as the five-year survival rate drops below 30 percent. In simple terms, today, almost half (45 percent) of all women with ovarian cancer will die within five years of their diagnosis.

Until a screening test is developed, public knowledge of the symptoms of ovarian cancer and comprehensive, effective treatment protocols are the keys to reduced mortality rates. The CDC Ovarian Cancer Control Initiative, NIH and NCI work together to support programs and research grants that seek to improve early detection and treatment and educate women and health care providers about ovarian cancer, thereby increasing awareness and ultimately saving lives.

THE OVARIAN CANCER CONTROL INITIATIVE AT THE CENTERS FOR DISEASE CONTROL AND PREVENTION

The CDC Ovarian Cancer Control Initiative plays an essential role in our Nation's fight to eliminate suffering and death from ovarian cancer. Created by Congress in 2000, the program coordinates and funds health activities aimed at identifying and filling any gaps in knowledge of ovarian cancer diagnosis and treatment. According to the program website, "CDC enhances the limited knowledge about ovarian cancer by initiating research projects with partners, colleagues and national organizations to help identify factors related to early disease detection and treatment and survivorship." The CDC Ovarian Cancer Control Initiative actively partners with State cancer registries and cancer centers across the country.

As the Nation's leading public health agency, the CDC plays an important role in translating and delivering research discoveries at the community level, especially ensuring that those populations disproportionately affected by cancer receive the benefits of our Nation's investment in medical research. With its extensive network of health professionals and cancer registries, the CDC is the optimal Federal agency for such work.

EARLY DETECTION AND AWARENESS

Most women and many health professionals remain unaware of the signs and symptoms associated with ovarian cancer. Consequently, many women suffer with the disease for months, even years, prior to receiving an accurate—and often fatal—diagnosis. Since there is no effective screening tool for ovarian cancer, it is imperative that women and their health care providers be aware of the multiple ways that ovarian cancer can present in a woman through symptoms. The CDC Ovarian Cancer Control Initiative is unique among CDC cancer programs. With no screening tool, the goal of the Ovarian Cancer Control Initiative is to learn more about current practice and identify areas of knowledge and practice patterns that need improvement to reduce the overwhelming burden of ovarian cancer.

STANDARDS OF CARE AND TREATMENT

The efforts of the CDC Ovarian Cancer Control Initiative also are targeted at improving prognosis for women currently living with and fighting the disease. Investigation into early symptoms, survival trends based on care provided, and research into general epidemiology will fill in information gaps to provide a stable body of knowledge which will guide future research. Most significantly, examination of survival trends based on care received contributes to the development of best practice guidelines for women with ovarian cancer. Currently, research funded by the Ovarian Cancer Control Initiative addresses four public health questions:

—What factors influence risk perception and how does risk perception affect screening behaviors?
—What are the primary diagnostic pathways in the diagnosis of ovarian cancer?
—Are women receiving optimal surgical and chemotherapy treatments?
—Are women receiving optimal end-of-life care?

Investigation into these questions will allow the CDC to maximize screening effectiveness by primary care physicians, improve early detection and diagnosis and provide physicians with "best practice" guidelines for women diagnosed with ovarian cancer. According to the CDC, $2.2 billion is spent on treatment for ovarian cancer each year. This figure could greatly be reduced with earlier diagnoses and more efficient practice guidelines.

CDC OVARIAN CANCER CONTROL INITIATIVE-FUNDED GRANTS

Grants supported by the CDC Ovarian Cancer Control Initiative have covered a diverse array of activities over the past six years, all aimed at accomplishing the program's mission of increasing awareness and improving treatment and survivorship of ovarian cancer. Current on-going ovarian cancer studies include the following:

—The Division of Cancer Prevention and Control (DCPC) at the CDC is investigating the influence of perceived risk of ovarian cancer on screening behaviors. This information will be used to maximize screening effectiveness in average and high risk women.

—Analysis of records of ovarian cancer patients and healthy women presenting symptoms similar to those associated with ovarian cancer to create more specific guidelines for symptom-recognition.

—Investigation into the relationship between patient characteristics, provider characteristics, diagnostic procedures and referral patterns leading to a positive diagnosis to create best practice guidelines for primary care physicians.

—Investigation into current surgical and chemotherapy practices for women diagnosed with ovarian cancer to develop best practice guidelines and to identify the demographics of women who typically receive poor treatment plans.

—Research and development of end-of-life care guidelines to prevent undue suffering in women with ovarian cancer.

BOOSTING THE CDC'S OVARIAN CANCER PREVENTION AND AWARENESS EFFORTS

In only six years of existence, the CDC Ovarian Cancer Control Initiative has made important contributions to better understanding and awareness of the disease. However, until the development of a valid and reliable screening test, more must be done to increase awareness and recognition of the symptoms of ovarian cancer. The full impact and benefits of CDC Ovarian Cancer Control Initiative efforts will not be fully realized unless the results are effectively translated into public health interventions.

The CDC Ovarian Cancer Control Initiative must continue to build its research efforts, but needs enhanced funding to move research results out to health care providers and women. Most significantly, increased resources are needed for a national effort to educate primary care providers on the signs and symptoms of ovarian cancer. These physicians and nurses are the most likely group to encounter women presenting with ovarian cancer warning signs and symptoms that, if recognized early, could lead to a faster diagnosis and therefore an increased chance of survival.

Additional funding in fiscal year 2007 will enable the CDC to expand the reach and scope of its current ovarian cancer initiatives to help advance our Nation's efforts to reduce and prevent ovarian cancer morbidity and mortality. The allocation of $7.5 million in fiscal year 2007 will continue the excellent progress being made and would help expand the program's efforts to include:

—Development and implementation of two critical and complementary national campaigns about the signs and symptoms of ovarian cancer:

—(A) A public education campaign with a focus on the signs and symptoms of ovarian cancer, the importance of regular monitoring for high risk populations and strategies for risk reduction.

—(B) A targeted education and awareness campaign involving primary care physicians.

—Examination of the epidemiology of ovarian cancer and development of appropriate strategies for addressing issues related to incidence and survival in minority populations.

—Training of health care professionals in best practices for treating ovarian cancer, emphasizing referral to gynecologic oncologists for optimal survival outcomes.

A SUSTAINED COMMITMENT TO FUND CANCER RESEARCH

Our Nation has reaped many benefits from past Federal investments in biomedical research at the NIH. The Alliance has joined with the broader health community in urging Congress to provide NIH $29.7 billion and NCI $5.034 billion in

fiscal year 2007 to allow these agencies to sustain their efforts while also having the resources to avoid the severe disruption to that progress that would result from a minimal funding increase. The requested increase in NCI allocations represents our national battle plan against cancer, focusing on critical ongoing research and promising research opportunities.

When funding stagnates or does not keep pace with inflation, progress in critical research programs can be halted or slowed significantly. Inadequate funding for the NIH, NCI and the CDC can result in inadequate funding for the lesser-known or less popular—yet terribly devastating—diseases such as ovarian cancer. The requested funding levels would provide the minimum resources required to preserve our cancer research enterprise and maintain the current pace of discovery.

SUMMARY AND CONCLUSION

The Alliance maintains a long-standing commitment to work with Congress, the Administration, and other policymakers and stakeholders to improve the survival rate from ovarian cancer through education, public policy, research and communication. Please know that we appreciate and understand that Congress has limited resources to allocate, but we believe the health and safety of American women are imperative to the strength of our Nation and should be a national priority. We are concerned that without increased funding to bolster and expand ovarian cancer education, awareness and research efforts, the Nation will continue to see growing numbers of women losing their battle with this terrible disease.

On behalf of the entire ovarian cancer community—patients, family members, clinicians and researchers—we thank you for your leadership and support of Federal programs that seek to reduce and prevent suffering from ovarian cancer. Thank you in advance for your support of the funding allocations we have requested for the CDC Ovarian Cancer Control Initiative, NIH and NCI. Please know that we stand ready to serve as a resource for any information you may need. Thank you for the opportunity to submit testimony on fiscal year 2007 ovarian cancer funding.

PREPARED STATEMENT OF THE POPULATION ASSOCIATION OF AMERICA/ASSOCIATION OF POPULATION CENTERS

INTRODUCTION

Thank you, Mr. Chairman Specter, Mr. Ranking Member Harkin, and other distinguished members of the subcommittee, for this opportunity to express support for the National Institutes of Health (NIH) and the National Center for Health Statistics (NCHS)—two agencies important to our organizations.

BACKGROUND ON THE PAA/APC AND DEMOGRAPHIC RESEARCH

The PAA is a scientific organization comprised of over 3,000 population research professionals, including demographers, sociologists, and economists. The APC is a similar organization comprised of over 30 universities and research groups that foster collaborative demographic research and data sharing, translate basic population research for policy makers, and provide educational and training opportunities in population studies. Over 30 population research centers are located throughout the country, including two in Ohio (Bowling Green State University and Ohio State University) and two in Pennsylvania (Pennsylvania State University and the University of Pennsylvania).

Demography is the study of populations and how or why they change. Demographers, as well as other population researchers, collect and analyze data on trends in births, deaths, and disabilities as well as racial, ethnic, and socioeconomic changes in populations. Major policy issues population researchers are studying include the demographic causes and consequences of population aging, trends in fertility, marriage, and divorce and their effects on the health and well being of children, and immigration and migration and how changes in these patterns affect the ethnic and cultural diversity of our population and the Nation's health and environment.

The NIH mission is to support research that will improve the health of our population. The health of our population is fundamentally intertwined with the demography of our population. Recognizing the connection between health and demography, the NIH supports population research programs primarily through the National Institute on Aging (NIA) and the National Institute of Child Health and Human Development (NICHD).

NATIONAL INSTITUTE ON AGING

Over the next 25 years, the number of individuals age 65 and older will likely double, reaching 70.3 million and comprising a larger proportion of the entire population, rising from 13 percent today to 20 percent in 2030.[1] This substantial growth in the older population is driving policymakers to consider dramatic changes in Federal entitlement programs, such as Medicare and Social Security, and other budgetary changes that could affect programs serving the elderly. Further, the macroeconomic and global impact of population aging on competitiveness in the world economy is becoming a bigger issue. To inform this debate, policymakers need objective, reliable data about the antecedents and impact of changing social, demographic, economic, and health characteristics of the older population. The NIA Behavioral and Social Research (BSR) program is the primary source of Federal support for research on these topics.

In addition to supporting an impressive research portfolio, that includes the prestigious Centers of Demography of Aging Program, the NIA BSR program also supports several large, accessible data surveys. Two such surveys, the National Long-Term Care Survey (NLTCS) and the Health and Retirement Study (HRS) have become seminal sources of information to assess the health and socioeconomic status of older people in the United States. By using NLTCS data, investigators identified the declining rate of disability in older Americans first observed in the mid-1990s—a trend that continued and even accelerated. This trend, if continued, could have momentous impact on reducing the need for costly long-term care. The HRS, which was launched in 1992 and has tracked 27,000 people, has provided data on a number of issues, including the role families play in the provision of resources to needy elderly and the economic and health consequences of a spouse's death. The Social Security Administration recognizes and funds the HRS as one of its "Research Partners" and posts the study on its home page to improve its availability to the public and policymakers. In 2005, the Center for Medicare and Medicaid Services (CMS) funded a supplemental survey using the HRS to provide CMS with timely information on who is likely to enroll in the new Medicare Part D prescription drug program and how those decisions are related to knowledge of the program, drug costs, and use.

With additional support in fiscal year 2007, the NIA BSR program could fully fund its existing centers and support its ongoing surveys. Additional support would allow NIA to expand the centers' role in understanding the domestic macroeconomic as well as the global competitiveness impact of population aging. NIA could also use additional resources to support individual investigator awards by precluding an 18 percent cut in its existing grants, improving its funding payline, which is now in the 10th percentile, and sustaining training and research opportunities for new investigators, which are being heavily cut back.

NATIONAL INSTITUTE ON CHILD HEALTH AND HUMAN DEVELOPMENT

Since its establishment in 1968, the NICHD Center for Population Research has supported research on population processes and change. Today, this research is housed in the Center's Demographic and Behavioral Sciences Branch (DBSB). The Branch encompasses research in four broad areas: family and fertility, mortality and health, migration and population distribution, and population composition. In addition to funding research projects in these areas, DBSB also supports a highly regarded population research infrastructure program and a number of large database studies, including the Fragile Families and Child Well Being Study and National Longitudinal Study of Adolescent Health.

NICHD-funded demographic research has consistently provided critical scientific knowledge on issues of greatest consequence for American families: work-family conflicts, marriage and childbearing, childcare, and family and household behavior. However, in the realm of public health, demographic research is having an even larger impact, particularly on issues regarding adolescent and minority health. For example, in 2006, researchers with the National Longitudinal Study of Adolescent Health, reported findings illustrating that by the time they reach early adulthood (age 19–24), a large proportion of American youth have begun the poor practices contributing to three leading causes of preventable death in the United States: smoking, poor diet and physical inactivity, and alcohol abuse. This study is striking in that it found the health situation of young people—in terms of behavior, health conditions, and access to and use of care—deteriorates markedly between the teen and young adult years. The study reinforces the importance of educating young peo-

[1] Federal Interagency Forum on Aging Related Statistics. Older Americans 2000: Key Indicators of Well-Being. 2000.

ple about adopting healthy lifestyles after they leave high school and the parental home.

Understanding the role of marriage and stable families in the health and development of children is another major focus of the NICHD DBSB. Consistently, research has shown children raised in stable family environments have positive health and development outcomes. Therefore, NICHD supports research to elucidate factors that contribute to family formation and strong partnerships. Recent findings have identified factors that can destabilize relationships between new parents. These factors include serious health or developmental problems of the parents' child, lower earnings, less education, and a father who has other children with different mothers. Policymakers and community programs can use these findings to support unstable families and improve the health and well being of children.

With additional support in fiscal year 2007, NICHD could restore full funding to its large-scale surveys, which serve as a resource for researchers nationwide. Furthermore, the Institute could apply additional resources toward improving its funding payline, which has gone from the 20th percentile range in 2003 to the 10th percentile in January 2006. Additional support could be used to preclude cuts of 17 percent to 22 percent in applications approved for funding and to support and stabilize essential training and career development programs to prepare the next generation of researchers.

NATIONAL CENTER FOR HEALTH STATISTICS

Located within the Centers for Disease Control (CDC), the National Center for Health Statistics (NCHS) is the Nation's principal health statistics agency, providing data on the health of the U.S. population and backing essential data collection activities. Most notably, NCHS funds and manages the National Vital Statistics System, which contracts with the States to collect birth and death certificate information. NCHS also funds a number of complex large surveys to help policy makers, public health officials, and researchers understand the population's health, influences on health, and health outcomes. These surveys include the National Health and Nutrition Examination Survey, National Health Interview Survey, and National Survey of Family Growth. Together, NCHS programs provide credible data necessary to answer basic questions about the state of our Nation's health.

In fiscal year 2006, Congress provided NCHS with the same level of funding as in fiscal year 2005, and the Administration has recommended NCHS receive the same level in fiscal year 2007. For fiscal year 2007, the Friends of NCHS recommends the agency receive $139 million, a $30 million increase over the fiscal year 2006 level. This funding is needed to, among other things, cover cost increases in basic survey operations, improve data timeliness and access to data, and expand and improve data collection to capture much needed information on issues such as health disparities, assisted living, and community health centers.

RECOMMENDATIONS

At a time when our Nation is poised to reap the promise of the past investment made in the NIH, the agency is facing the prospect receiving flat funding in fiscal year 2007. When inflation is factored in, the NIH could actually be facing being funded for the fourth year in a row below the rate of biomedical research inflation. PAA and APC join other organizations in expressing our concern about the precarious NIH funding trajectory. Already, NIH has seen a 15 percent reduction in new grants between fiscal year 2003 and fiscal year 2006. For population research, increased support is needed to ensure the best research projects, including new and innovative projects, are being awarded, surveys and databases are supported, and training programs are stabilized. With respect to NCHS, funding is needed to sustain and update its major operations.

The PAA and APC join the Ad Hoc Group for Medical Research in supporting an fiscal year 2007 appropriation of $29.75 billion, a 5 percent increase over the fiscal year 2006 appropriation, for the NIH. In addition, the Friends of NCHS, support a fiscal year 2007 appropriation of $139 million, a 30 percent increase over the fiscal year 2006 appropriation, for the NCHS. Finally, PAA and APC urge the subcommittee to include language in the fiscal year 2007 bill, allowing continuation of the National Children's Study at the NICHD.

Thank you for considering our requests and for supporting Federal programs that benefit the field of demographic research.

PREPARED STATEMENT OF THE PULMONARY HYPERTENSION ASSOCIATION

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS

—$250,000 within the Centers for Disease Control and Prevention for a pulmonary hypertension awareness and education program.
—A 5 percent increase for the National Heart, Lung and Blood Institute and the establishment of "Specialized Centers of Clinically Orientated Research" on Pulmonary Hypertension at the Institute.
—$25 million for the Health Resources and Services Administration's "Gift of Life" Donation Initiative.

Mr. Chairman, thank you for the opportunity to submit testimony on behalf of the Pulmonary Hypertension Association.

I am honored today to represent the hundreds of thousands of Americans who are fighting a courageous battle against this devastating disease. Pulmonary hypertension is a serious and often fatal condition where the blood pressure in the lungs rises to dangerously high levels. In PH patients, the walls of the arteries that take blood from the right side of the heart to the lungs thicken and constrict. As a result, the right side of the heart has to pump harder to move blood into the lungs, causing it to enlarge and ultimately fail.

PH can occur without a known cause or be secondary to other conditions such as; collagen vascular diseases (i.e., scleroderma and lupus), blood clots, HIV, sickle cell, and liver disease. PH does not discriminate based on race, gender or age. Patients develop symptoms that include shortness of breath, fatigue, chest pain, dizziness, and fainting. Unfortunately, these symptoms are frequently misdiagnosed, leaving patients with the false impression that they have a minor pulmonary or cardiovascular condition. By the time many patients receive an accurate diagnosis, the disease has progress to a late stage, making it impossible to receive a necessary heart or lung transplant.

While new treatments are available, unfortunately, PH is frequently misdiagnosed and often progresses to late stages by the time it is detected. Although PH is chronic and incurable with a poor survival rate, the new treatments becoming available are providing a significantly improved quality of life for patients. Recent data indicates that the length of survival is continuing to improve, with some patients able to manage the disorder for 20 years or longer.

Fifteen years ago, when three patients who were searching to end their own isolation founded the Pulmonary Hypertension Association, there were less than 200 diagnosed cases of this disease. It was virtually unknown among the general population and not well known in the medical community. They soon realized that this was unacceptable, and formally established PHA, which is headquartered in Silver Spring, Maryland.

Today, PHA includes:

—Over 6,000 patients, family members, and medical professionals.
—An international network of over 120 support groups.
—An active and growing patient telephone helpline.
—A new and fast-growing research fund. (A cooperative agreement has been signed with the National Heart, Lung, and Blood Institute to jointly create and fund five, five-year, mentored clinical research grants and PHA has awarded eleven Young Researcher Grants.)
—Numerous electronic and print publications, including the first medical journal devoted to pulmonary hypertension—published quarterly and distributed to all cardiologists, pulmonologists and rheumatologists in the United States.

Mr. Chairman, at the age of 5, my wife and I noticed that our daughter, Emily, could not keep up with the other kids in the neighborhood. She seemed to lack the energy and strength to run and play. This condition seemed to worsen to the point to where she would have to stop and rest after coming down the steps in the morning. We noticed that when she was sitting on the bottom step in the morning, her lips appeared to have a bluish color.

After pressing for an answer to these problems for several months, Emily was finally diagnosed with pulmonary hypertension and the doctors gave a probable remaining lifespan of three years. That unforgettable day was 8 years ago and, as you can see, Emily is still here today. She is here because of continued advances in the treatment of pulmonary hypertension and by the grace of God. There is however, NO cure for pulmonary hypertension. Thanks to congressional action, Emily's chances of a full life have greatly increased. We need, however, additional support for research and related activities to continue to develop treatments that will extend the published NIH life expectancy beyond the 2.8 years after diagnosis.

(A) National Heart, Lung and Blood Institute

Mr. Chairman, PHA commends the National Heart, Lung and Blood Institute (NHLBI) for its strong support of PH research. According to leading researchers in the field, we are on the verge of significant breakthroughs in our understanding of the disease and the development of new and advanced treatments. Ten years ago, a diagnosis of PH was essentially a death sentence, with only one approved treatment for the disease. Thanks to advancements made through the public and private sector, patients today are living longer and better lives with a choice of five FDA approved therapies. Recognizing we have made tremendous progress, we are also mindful that we are a long way from where we want to be, and that is; (1) the management of pulmonary hypertension as a treatable chronic disease, and (2) A CURE.

Mr. Chairman, it is our understanding that NHLBI is poised to establish "Specialized Centers of Clinically Orientated Research" in pulmonary hypertension later this year. We are very excited about the promise these Centers hold for the future development of new treatments and we encourage the subcommittee to support this worthy investment. In addition, we applaud NHLBI and the NIH Office of Rare Diseases for their plans to co-sponsor a two-day scientific conference on pulmonary hypertension this Fall. This important event will bring together leading PH researchers from the United States and abroad to discuss the state of the science in pulmonary hypertension and future research directions.

In order to facilitate the establishment of the Specialized Centers of Clinically Orientated Research and maintain promising research currently underway on PH, the Pulmonary Hypertension Association encourages the subcommittee to provide NHLBI with a 5 percent increase in funding in fiscal year 2007.

(B) Centers for Disease Control and Prevention

PHA applauds the subcommittee for its leadership over the years in encouraging the Centers for Disease Control and Prevention to initiate a Pulmonary Hypertension Education and Awareness Program. We know for a fact that Americans are dying due to a lack of awareness of PH, and a lack of understanding about the many new treatment options. This unfortunate reality is particularly true among minority and underserved populations. However Mr. Chairman, you don't have to rely solely on our word regarding the need for additional education and awareness activities. On November 11, 2005 the CDC released a long awaited Morbidity and Mortality Report on pulmonary hypertension. In that report, the CDC states:

(1) "More research is needed concerning the cause, prevention, and treatment of pulmonary hypertension. Public health initiatives should include increasing physician awareness that early detection is needed to initiate prompt, effective disease management. Additional epidemiologic initiatives also are needed to ascertain prevalence and incidence of various pulmonary hypertension disease entities." (Page 1, MMWR Surveillance Summary—Vol. 54 No. SS–5)

(2) "Prevention efforts, including broad based public health efforts to increase awareness of pulmonary hypertension and to foster appropriate diagnostic evaluation and timely treatment from health care providers, should be considered. The science base for the etiology, pathogenesis, and complications of pulmonary hypertension disease entities must be further investigated to improve prevention, treatment, and case management. Additional epidemiologic activities also are needed to ascertain the prevalence and incidence of various disease entities." (Page 7, MMWR Surveillance Summary—Vol. 54 No. SS–5)

Mr. Chairman, we are grateful to CDC for their recent support of a DVD highlighting the proper diagnosis of PH. However, despite repeated encouragement from the subcommittee over the past 5 years, CDC has not taken any steps to establish an education and awareness program on PH. Therefore, we respectfully request that you provide $250,000 in fiscal year 2007 for the establishment of a PH awareness initiative through the Pulmonary Hypertension Association.

(C)"Gift of Life" Donation Initiative at HRSA

Mr. Chairman, PHA applauds the success of the Health Resources and Services Administration's "Gift of Life" Donation Initiative. This important program is working to increase organ donation rates across the country. Unfortunately, the only "treatment" option available to many late-state PH patients is a lung or heart and lung transplantation. This grim reality is why PHA established "Bonnie's Gift Project." "Bonnie's Gift" was started in memory of Bonnie Dukart, one of PHA's most active and respected leaders. Bonnie was a PH patient herself. She battled with PH for almost 20 years until her death in 2001 following a double lung transplant. Prior to her death, Bonnie expressed an interest in the development of a pro-

gram within PHA related to transplant information and awareness. PHA will use "Bonnie's Gift" as a way to disseminate information about PH, transplantation and the importance of organ donation to our community and organ donation cards.

PHA has had a very successful partnership with HRSA's "Gift of Life" Donation Program in recent years. Collectively, we have worked to increase organ donation rates and raise awareness about the need for PH patients to "early list" on transplantation waiting lists. For fiscal year 2007, PHA recommends an appropriation of $25 million (an increase of $2 million) for this important program.

Mr. Chairman, once again thank you for the opportunity to present the views of the Pulmonary Hypertension Association. We look forward to continuing to work with you and the subcommittee to improve the lives of pulmonary hypertension patients.

PREPARED STATEMENT OF THE SOCIETY FOR INVESTIGATIVE DERMATOLOGY

SUMMARY OF THE SOCIETY FOR INVESTIGATIVE DERMATOLOGY'S FISCAL YEAR 2007 RECOMMENDATIONS

(1) A 5 percent increase for all of the National Institutes of Health (NIH) and for the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS).

(2) Establishment of a skin disease clinical trials network that will collect baseline data for specific orphan diseases and facilitate the exchange of scientific data across disciplines and institutes.

(3) Encourage NIAMS to develop collaborative funding mechanisms with other NIH institutes and private foundations that leverage skin biology studies as a developmental model that will serve for the advancement of research across a multitude of diseases and specialties.

(4) Encourage NIAMS to sponsor studies that capture general and skin disease specific measures in order to generate incidence, prevalence and quality of life data attributable to skin diseases.

(5) Increase the number of training awards through the NIH designed to facilitate the entry of more individuals into careers in skin disease research.

BACKGROUND

The Society for Investigative Dermatology (SID) was founded in 1938. Its 2,000 members represent over 40 countries worldwide, including scientists and physician researchers working in universities, hospitals and industry.

Our members are dedicated to the advancement and promotion of the sciences relevant to skin health and disease through education, advocacy, and the scholarly exchange of scientific information along with our colleagues from the American Academy of Dermatology.

This collective commitment to research is evidenced in the scientific journal published by the SID, the Journal of Investigative Dermatology. The Journal is a catalyst for the exchange of scientific information pertaining to the 3,000 skin diseases that afflict nearly 80 million Americans annually.

The purpose in presenting testimony is to increase awareness of the need for more skin research, based on the burden attributable to skin disease. It will also highlight some of the advancements that past support has enabled.

We join with the Ad Hoc Group for Medical Research Funding in asking for a 5 percent increase to the National Institutes of Health (NIH) and the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS).

BURDEN OF SKIN DISEASE

Prior bill report language directed NIAMS to "consider supporting the development of new tools to measure the burden of skin diseases, and the training of researchers in this important area". There only a handful of researchers working on NIH-sponsored research that will provide such measures.

Skin disease impacts our citizens more than previously estimated. A recent report released by the Society for Investigative Dermatology and the American Academy of Dermatology, "The Burden of Skin Disease", compiled data from only 21 of the known 3,000 skin diseases and disorders. The estimated economic costs to society each year from those 21 diseases totaled nearly $39 billion.

The true impact extends far beyond mere economics. These patients encounter discomfort and pain, physical disfigurement, disability, dependency and death. Skin conditions affect an individual's ability to interact with others and compromise the self-confidence of those inflicted.

One of the most striking findings in the study was the lack of general and skin-disease specific measures that are needed to generate data surrounding the incidence, prevalence, economic burden, quality of life, disability and handicaps attributable to these diseases.

We ask the Committee to devote the resources needed to develop components of national health surveys that capture dermatological data above and beyond skin cancer incidence and prevalence.

RESEARCH ADVANCES

Skin is the body's largest organ and serves as the primary barrier to external pathogens and toxins. Researchers at the NIH campus and institutions around the country are working diligently to define how the skin functions to protect us, how this fails in disease, and how compromised functions in disease can be restored.

Cell biology allows scientists to understand the life cycle of skin and hair-producing cells and identify the causes of disease, leading to better treatments and preventative measures. Advances in wound healing and skin ulcers are helping the growing aging population, those with diabetes, burn victims and our veteran population. Lasers continue to provide less invasive options for patients requiring surgery.

Fundamental discoveries resulting from skin biology and translational research have yielded advances that are broadly applicable to human development and disease. Continued investment is required to fully capitalize on these ground-breaking advances.

Important new research findings include the following:

—The genes responsible for skin cancer and inherited skin disorders have been identified, making targeted therapy possible.

—The molecular mechanisms of auto-immune and inflammatory skin diseases are better understood, allowing for the use of focused, selective immunosuppressive therapy with greater safety and efficacy.

—Oral medications to treat and prevent viral and fungal diseases have become available.

—Lasers have made possible the removal of disfiguring skin malformations.

—Modern phototherapy and photochemotherapy allow for more effective treatment of inflammatory skin disease, lymphoma, depigmenting disorders and auto-immune diseases.

—Retinoids and sunscreens have reduced the risk of skin cancer in the elderly, in transplant patients, and in other populations.

—Painless transdermal drug delivery has become available.

Recent developments in the areas of clinical epidemiology, biostatistics, economics, and the quantitative social sciences have begun to provide objective evaluation measures, although additional and improved measures are still desperately needed. These measures will help to identify effective interventions and allow us to better quantify contributions to the quality of life and health of Americans.

A significant portion of skin disease is chronic, resulting from aging, genetics and environmental and occupational exposure.

We ask the NIH to work to identify additional biomarkers in order to better understand skin disease pathways and interaction with other diseases and environmental factors.

TRANSLATING DISCOVERY TO TREATMENTS FOR AMERICANS

The goal of skin disease research is to improve the quality of life for the one in three Americans that suffer from skin disease. That goal is embedded in the collective missions of the SID and the intramural and extramural scientists funded through the skin portfolios of many of the 27 Institutes and Centers of the NIH.

Medical research organizations such as the SID are the direct recipients of the awards made possible through the rigorous peer-reviewed grant system in place at the NIH. The ultimate beneficiaries are the nearly 80 million Americans that stand to benefit from the discoveries resulting from research grants.

Inadequate levels of Federal funding have forced Institute administrators to reduce certain types of the available funding mechanisms currently in place at the NIH, to decrease success rates, to increase administrative cost reductions, to consider decreasing the number of awards, and to cut award levels in existing programs.

Unfortunately, this reality impairs the ability of hypothesis-driven research, the source of countless discoveries, to drive the research system. Adequate funding levels will allow the peer-review system to work at full potential, leading to findings that translate into better care for those suffering from debilitating diseases. Without

sufficient funding provided specifically for skin research, nearly one third of the Nation would be denied any hope for a better quality of life.

We are grateful for the past support that has been given to the NIH and ask you to look for innovative ways to avoid flat or decreased funding levels to these Institutes that are charged with improving the health of Americans.

PREPARED STATEMENT OF THE SOCIETY FOR MATERNAL-FETAL MEDICINE

The Society for Maternal-Fetal Medicine appreciates the opportunity to comment on the fiscal year 2007 budget for the National Institutes of Health. We are especially grateful for the Committee's support of the National Institute of Child Health and Human Development over the past years and urge your continued commitment to the critical medical research conducted and supported by the National Institutes of Health.

Established in 1977, the Society for Maternal-Fetal Medicine (SMFM) is a not-for-profit organization of over 2,000 members that are dedicated to improving perinatal care through research and education. Maternal-fetal medicine doctors have advanced knowledge of the obstetrical, medical, genetic and surgical complications of pregnancy and their effects on both the mother and fetus. The many advances in research have allowed the maternal-fetal medicine physician to provide the direct care needed to treat the special problems that high risk mothers and fetuses face.

The SMFM applauds the National Institute of Child Health and Human Development (NICHD) for its efforts to pursue research to understand, prevent and treat the abnormal events that can occur during pregnancy. For example:

Preterm birth.—Remains a leading cause of death, illness, and disability among infants during their first year of life. It poses great risks to both the infant and mother. Infants born too early are at higher risk than full-term babies for medical and developmental complications. The earlier the birth, the more risk of complications. In addition even without any neonatal conditions, these infants face serious adult complications including heart disease and diabetes resulting from their intrauterine environment and low birthweight.

NICHD-supported research has improved the outlook for preterm infants and families. The Maternal-Fetal Medicine Units (MFMU) Network established in 1986, to address issues pertaining to preterm births and low birth weight deliveries, has made steady and impressive strides in these areas.

Researchers recently found that:

—A substance in the urine of pregnant women can be measured to predict the later development of preeclampsia—a life-threatening complication of pregnancy.

—Weekly injections of 17-hydroxyprogesterone can reduce preterm birth by more than one third among women who are at increased risk of preterm delivery.

However, despite these efforts, the rate of preterm births continues to rise. SMFM therefore urges full support of the MFMU Network so that it can continue to address these issues.

In addition, full funding of the new Genomic and Proteomic Network will hasten a better understanding of the pathophysiology of premature birth and discover novel diagnostic biomarkers. Studies to be undertaken by this network will ultimately aid in formulating more effective interventional strategies to prevent premature birth.

Stillbirth.—Is a major public health issue with morbidity equal to that of all infant deaths. Despite this significant and persistent burden of stillbirths, they have remained largely unstudied and, for at least half of all stillbirths, the cause is undetermined. The NICHD cooperative network has initiated a pilot study with the full study planned to start this year. The information that will be obtained will aid in future research to improve preventive and therapeutic interventions and to understand the pathologic mechanisms leading to fetal death. Increased knowledge regarding the causes of stillbirths will benefit families who have experienced a loss, pregnant women, and their physicians, and may lead to the development and evaluation of improved clinical and preventive interventions. Full funding of this study is urgently needed.

Near-Term Births.—The preterm birth rate is now over 12 percent of all live births, and of these 75 percent are near term births. Near-term birth occurs after 35–37 weeks of gestation. It is estimated that this group encompasses 40 percent of Neonatal ICU admissions. These infants are at risk for sepsis; pneumonia; feeding difficulties; white matter damage; seizures; apnea; and remain at risk for higher morbidities in early infancy. This group of infants has not been well studied and may account for a portion of the increase in adverse long-term outcomes such as

autism, attention deficit disorders, and neurodevelopmental disorders. Additional funding will allow NICHD to facilitate the critical need for research in this area.

In addition to the need for funding for research, the state of funding for physician scientists and researchers has become a major problem and is in dire need of a fix.

Over the last decade, NICHD has responded to the scientific community's need for enhanced training programs to provide a solid framework for the development of physician scientists and researchers. The expansion of research training programs has included a substantial investment in the "T" (Training Programs) and "F" (Fellowship Programs) line and the expansion of the "K" (Research Career Awards) line. After completion of these programs it is anticipated that investigators will be competitive for research awards. However, given the substantial reduction in the payline, the new investigator's ability to be successful is severely restricted. It is imperative that NICHD identify and provide an opportunity for funding to investigators that NIH has already invested in through completion of training programs and who have demonstrated a commitment to a research career. It is of major concern to the scientific community that a cadre of scientists may be lost due to the stringent funding payline.

RECOMMENDATIONS

—The Society for Maternal-Fetal Medicine supports a 5 percent increase in fiscal year 2007 for the National Institutes of Health (above the fiscal year 2006 funding level) as recommended by the Ad Hoc Group for Medical Research, along with the National Health Council, the Campaign for Medical Research and Research!America.
—SMFM supports a 5 percent increase for the National Institute of Child Health and Human Development and urge full funding support for:
—the Maternal Fetal Medicine Unit Network
—the Genomic and Proteomic Network
—Research in the area of near-term births
—The stillbirth collaborative research network (SCRN)
—Physician scientists and researchers

Again, thank you for allowing SMFM the opportunity to express its concerns regarding the need for sustained funding in fiscal year 2007 for the critical research programs supported by the National Institute of Child Health and Human Development and the National Institutes of Health overall.

PREPARED STATEMENT OF THE SOCIETY OF NUCLEAR MEDICINE

The Society of Nuclear Medicine (SNM) appreciates the opportunity to submit written testimony for the record regarding Federal funding for biomedical research in fiscal year 2007. SNM is an international, scientific, professional organization with more than 16,000 members dedicated to promoting the science, technology, and practical application of nuclear medicine. Over the last 50 years, since biomedical imaging first began, the nuclear medicine community has had a positive working relationship with the National Institutes of Health (NIH). The research and development supported by NIH have made ground-breaking discoveries in the field of nuclear medicine. Similarly, NIH has benefited from the nuclear medicine research conducted through Federal funding of the Medical Applications and Measurement Science Program at the Department of Energy (DOE). Unfortunately, that $37 million in funding was eliminated in the fiscal year 2006 Energy and Water Appropriations bill. Therefore, the Society requests and strongly recommends that the Labor, Health and Human Services, and Education (LHHS) Appropriations Subcommittee work with the Energy and Water Development Appropriations Subcommittee to ensure that dedicated funding for nuclear medicine research is fully restored in fiscal year 2007.

WHAT IS NUCLEAR MEDICINE?

Nuclear medicine is an established specialty that performs noninvasive molecular imaging procedures to diagnose and treat diseases and determine the effectiveness of therapeutic treatments, whether surgical, chemical, or radiation. It contributes extensively to the treatments and diagnoses of patients with cancers of the brain, breast, blood, bone, bone marrow, liver, lungs, pancreas, thyroid, ovaries, and prostate. Molecular imaging continues to provide critical information to help doctors, technicians, and other health care personnel manage abnormalities of the heart, brain, and kidneys. In fact, recent advances in the detection and diagnosis of Alzheimer's disease can be attributed to nuclear medicine imaging procedures, specifi-

cally positron emission tomography (PET) scans. These advances—which were made possible by research performed by nuclear medicine professionals—helped lead the Centers for Medicare and Medicaid Services (CMS) to extend Medicare coverage to include PET scans for some beneficiaries who suffer from Alzheimer's and other dementia-related diseases.

The effect nuclear medicine has on the lives of men, women, and children suffering from cancer, heart, and brain diseases is far-reaching. Annually, more than 20 million men, women, and children require noninvasive molecular/nuclear medical procedures. These safe, cost-effective procedures include PET scans to diagnose and monitor treatments in cancer, cardiac stress tests that analyze heart function, bone scans for orthopedic injuries, and lung scans for blood clots. In addition, patients undergo procedures to diagnose liver and gall bladder functional abnormalities and to diagnose and treat hyperthyroidism and thyroid cancer.

IMPACT OF THE LOSS OF FEDERAL FUNDING FOR NUCLEAR MEDICINE RESEARCH ON NIH

In fiscal year 2006, the government abandoned its fifty-year commitment to supporting nuclear medicine research by eliminating funding for the Medical Applications and Measurement Science Program at the DOE and making no accommodation to transition nuclear medicine programs to another government agency. Over the years, the DOE Medical Applications and Measurement Science Program has generated advances in the field of molecular/nuclear medicine. For example, DOE funding provided the resources necessary for molecular/nuclear medicine professionals to develop PET scanners to diagnose and monitor the treatment of cancer. PET scans offer significant advantages over CT and MRI scans in diagnosing disease and are more effective in identifying whether cancer is present, if it has spread, if it is responding to treatment, and if a person is cancer free after treatment. In fact, the DOE has stated that this program supports "research in universities and in the National Laboratories, and occupies a critical and unique niche in the field of radiopharmaceutical research. The NIH relies on our basic research to enable them to initiate clinical trials."

The advances in molecular/nuclear medicine made possible by Federal funding of nuclear medicine research at the DOE include:

—Modeling Radiation Damage to the Lung: Treatment of thyroid disease and lymphomas using radioisotopes can cause disabling lung disease. Investigators at Johns Hopkins University have developed a Monte Carlo model that can be used to determine the probability of lung toxicity and be incorporated into a therapeutic regimen. This model will optimize the dose of radioactivity delivered to cancer cells and avoid untoward effects on the lung.

—New Radiopharmaceuticals with Important Clinical Applications: The DOE radiopharmaceutical science program has developed a number of innovative radiotracers at the University of California at Irvine for the early diagnosis of neuro-psychiatric illnesses, including Alzheimer's disease, schizophrenia, depression, and anxiety disorders.

—Imaging Gene Expression in Cancer Cells: Images of tumors in whole animals that detect the expression of three cancer genes were accomplished for the first time by investigators at Thomas Jefferson University and the University of Massachusetts Medical Center. This advanced imaging technology will lead to the detection of cancer in humans using cancer cell genetic profiling.

—Rapid Preparation of Radiopharmaceuticals for Clinical Use: The DOE-sponsored program at the University of Tennessee has developed a new method for preparing radiopharmaceuticals by placing a boron-based salt at the position that will be occupied by the radiohalogen. The method has been used to prepare a variety of cancer-imaging agents.

—Smaller, More Versatile PET Scanners: Brookhaven National Laboratory (BNL) has completed a prototype mobile PET scanner, which will record images in the awake animal. The mobile PET will be able to acquire positron-generated images in the absence of anesthesia-induced coma and correct for motion of the animal. The long-term goal is to develop PET instrumentation able to diagnose neuro-psychiatric disorders in children.

—Highest Resolution PET Scanner Developed: Scientists at the Lawrence Berkeley National Laboratory (LBNL) have developed the world's most sensitive PET scanner. The instrument is 10-times more sensitive than a conventional PET scanner and became operational in 2005.

With restored Federal funding, essential molecular/nuclear medicine research will continue at universities, research institutions, national laboratories, and small businesses. Moreover, research with radiochemistry, genomic sciences, and structural biology will be able to usher in a new era of mapping the human brain and using

specific radiotracers and instruments to more precisely diagnose neuro-psychiatric illnesses and cancer.

The future of life-saving therapies and cutting-edge research in molecular/nuclear medicine and imaging depends on the restoration of Federal funding for nuclear medicine research.

SUSTAIN AND SEIZE RESEARCH OPPORTUNITIES

For decades, Americans and people from across the world have benefited from the strong Federal investment in nuclear medicine and biomedical research at NIH. SNM hopes that the LHHS subcommittee will continue that trend and fund NIH and the National Institute of Biomedical Imaging and Bioengineering (NIBIB) and the National Cancer Institute (NCI) at sufficient levels in fiscal year 2007.

SNM is proud to join its colleagues in the public health community in recommending that NIH receive $29.7 billion in fiscal year 2007 funding—the same level of funding that is included in the Senate-passed budget resolution. This funding level would permit NIH to sustain and build upon its current research activities, which are a byproduct of the recent NIH budget-doubling effort. Even a minimal decrease or slowed momentum in increased funding for NIH could cause severe disruption in the Institutes' research activities and capabilities.

Research in biomedical imaging and bioengineering is progressing rapidly, and recent technological advances have revolutionized the diagnosis and treatment of disease. In 2000, NIBIB was created to specifically focus on biomedical imaging and bioengineering. It has made great strides in helping the health care community and patients recognize and understand different diseases and disorders. Pancreatic transplantation, brain scans, and improvement in epilepsy surgeries are just a few examples of how NIBIB research is helping to diagnose and treat patients. In order for NIBIB to continue its important work, SNM requests that Congress provide it with $388 million in Federal funding for fiscal year 2007. This funding level would allow NIBIB to further its research, development, and application of emerging and cutting-edge biomedical technologies to facilitate improved disease detection, management, and prevention.

In addition, SNM advocates that NCI receive $5.034 billion in fiscal year 2007. The American Cancer Society predicts that more than 1.4 million Americans will be diagnosed with cancer in 2005. Significant gains have been made in the war on cancer, and there have been successful breakthroughs in diagnosing and treating this terrible disease. Currently, PET scans are available to detect more than a dozen types of cancer. Cancer research is leading to new therapies that translate into longer survival and improved quality of life for cancer patients. Extraordinary advances in cancer research have resulted because of the strong commitment by the Federal, State, and local governments in combating cancer.

CONCLUSION

As outlined above, SNM has a strong interest in making sure that biomedical research in the United States is sufficiently funded. Also, since NIH relied on the pool of research conducted by the DOE's Medical Applications and Measurement Science Program, SNM would like to stress the impact that the loss of Federal funding for nuclear medicine research will have on NIH. In order to ensure that the positive effects and results of research and development are not seriously compromised, SNM advocates the allocation of $29.7 billion for NIH, including $388 million for NIBIB and $5.034 billion for NCI, and requests that the LHHS Appropriations subcommittee work with the Energy and Water Development Appropriations Subcommittee to ensure that Federal funding for nuclear medicine research is fully restored.

SNM stands ready to work with policymakers on both sides of the aisle to advance biomedical research and innovation to help reduce and prevent suffering from disease for all Americans. Again, on behalf of the members of SNM, I thank you for the opportunity to submit testimony regarding the need for increased Federal funding for biomedical research.

PREPARED STATEMENT OF THE SOCIETY FOR WOMEN'S HEALTH RESEARCH AND WOMEN'S HEALTH RESEARCH COALITION

On the behalf of the Society for Women's Health Research and the Women's Health Research Coalition, we are pleased to submit the following testimony in support of biomedical research, and more specifically women's health research.

The Society for Women's Health Research is the only national non-profit women's health organization whose mission is to improve the health of women through research, education, and advocacy. Founded in 1990, the Society brought to national attention the need for the appropriate inclusion of women in major medical research studies and the need for more information about conditions affecting women disproportionately, predominately, or differently than men. In 1999, the Women's Health Research Coalition was created by the Society as a grassroots advocacy effort consisting of scientists, researchers, and clinicians from across the country that are concerned and committed to improving women's health research.

The Society and Coalition are committed to advancing the health of women through the discovery of new and useful scientific knowledge. We believe that sustained funding for biomedical and women's health research programs conducted and supported across the Federal agencies is necessary if we are to accommodate the health needs of the population and advance the Nation's research capability.

NATIONAL INSTITUTES OF HEALTH

From decoding the human genome to elucidating the scientific components of human physiology, behavior, and disease, scientists are unearthing exciting new discoveries which have the potential to make our lives and the lives of our families longer and healthier. The National Institutes of Health (NIH) has made this all possible by conducting and supporting our Nation's biomedical research. World-class researchers, scientists, and programs at NIH are dedicated to understanding how the human body works and to gain insight into countless diseases and disorders. Congressional investment and support for NIH has made the United States the world leader in medical research and has had a direct and significant impact on women's health research and the careers of women scientists in the last decade.

Great strides and advancements have been made since the doubling of the NIH budget from $13.7 billion in 1998 to $27 billion in 2003. However, we are concerned that the momentum driving new research will erode under the current budgetary constraints. Medical research needs to be considered an essential investment—an investment in thousands of newly trained and aspiring scientists; an investment to remain competitive in the global marketplace; and an investment in our Nation's health. In fact, a recent national poll indicated that a 58 percent of Americans believe that a strong investment in research and science is critical not only for our global scientific leadership but for the health of our economy and citizens. Furthermore, 94 percent consider accelerating medical research an important national priority—comparable to homeland security.

The administration's fiscal year 2007 budget request of $28.6 billion for NIH is unraveling the successes from the doubling of NIH's budget. The proposed budget would freeze NIH funding at the fiscal year 2006 appropriated level of $28.57 billion and cut most individual Institute budgets from 0.5 to 0.8 percent. The proposed decrease does not keep pace with the inflation rate. The annual change in the Biomedical Research and Development Price Index (BRDPI) will increase to 4.1 percent in fiscal year 2006 and 3.8 percent in fiscal year 2007 and fiscal year 2008. BRDPI indicates how much the NIH budget would need to change to maintain purchasing power to compensate for the average increase in prices and to maintain research activity at the previous year's level.

A flat-funded budget will have a negative impact on the number of grants NIH will be able to fund. NIH predicts total the total number of grants funded will decrease by 656. The number of new grants funded by NIH has already dropped by nearly fifteen percent from 10,393 in fiscal year 2003 to an estimated 9,062 for fiscal year 2006. The shrinking pool of available grants will have a significant impact on scientists as they depend upon NIH support to help cover their salaries and laboratory expenses. If one fails to obtain a grant they will be less likely to achieve tenure and new, less established researchers will be forced to consider other careers, resulting in a loss of the critical workforce needed to sustain America's cutting edge in biomedical research.

In order to continue the momentum of scientific advancement and expedite the translation of research from the laboratory to the patient, the Society calls for a five percent increase for the NIH fiscal year 2007. In addition, we request that you strongly encourage the NIH to assure that women's health research receives resources sufficient to meet the health needs of all women.

Scientists have long known of the anatomical differences between men and women, but only within the past decade have they begun to uncover significant biological and physiological differences. Sex-based biology, the study of biological and physiological differences between men and women, has revolutionized the way that the scientific community views the sexes.

Sex differences play an important role in disease susceptibility, prevalence, time of onset and severity and are evident in cancer, obesity, coronary heart disease, autoimmune, mental health disorders, and other illnesses. This research needs to be supported and encouraged. Congress recognizes this importance and should support NIH at an appropriate level of funding and direct NIH to continue expanding research into sex-based biology.

Sex differences research in heart disease has long been neglected. Heart disease is the number one killer of women in United States, killing 493,623 women. Information gaps related to the development, diagnosis, and treatment of heart disease among women are enormous, in part because women continue to be underrepresented in heart-related research studies. As a result, women face misdiagnosis, delayed diagnosis, under-treatment and mistreatment of their heart problems. In fiscal year 2005 the Centers for Medicare and Medicaid Services highest expenditure in women's health 2005 was cardiovascular/pulmonary services. Despite large expenditures to treat heart disease, little funding is targeted at research that could lead to more effective prevention, diagnosis, and treatment. In order to address the discrepancies, the Society in conjunction with WomenHeart: the National Coalition for Women with Heart Disease compiled a list of ten questions that must be answered if women are to receive optimal cardiovascular care and treatment. The 10 unanswered research questions are:

1. Why do women receive significantly fewer referrals for advanced diagnostic testing and treatments for heart disease than men, and how can the referral rate for women be increased?
2. What are the best tools and methods for assessing women's risk of heart disease?
3. What are the best strategies for preventing heart disease in women?
4. What treatments for heart disease work best for women?
5. What are the most effective methods and treatments for diastolic heart failure, which is the most common form of congestive heart failure in women?
6. How can the heart disease diagnosis and care disparities between white women and women of color be eliminated?
7. What are the biological differences between men and women in the location, type, and heart disease risk level associated with fat deposits, and what determines these differences?
8. How do sex differences in the regulation of heart rhythm affect risk of heart disease and response to treatment?
9. What is the role of inflammation in heart disease in women?
10. Why are women ages 50 and younger more likely to die following a heart attack than men of the same age?

We strongly believe and encourage that these questions serve as a guide for NIH and other health related agencies while developing research portfolios.

OFFICE OF RESEARCH ON WOMEN'S HEALTH

The NIH Office of Research on Women's Health (ORWH) has a fundamental role in coordinating women's health research at NIH, advising the NIH Director on matters relating to research on women's health; strengthening and enhancing research related to diseases, disorders, and conditions that affect women; working to ensure that women are appropriately represented in research studies supported by NIH; and developing opportunities for and support of recruitment, retention, re-entry and advancement of women in biomedical careers. ORWH strives to address sex and gender perspectives of women's health and women's health research, as well as differences among special populations of women across the entire life span, from birth through adolescence, reproductive years, menopausal years and elderly years.

Two highly successful programs supported by ORWH that are critical to furthering the advancement of women's health research are Building Interdisciplinary Research Careers in Women's Health (BIRCWH) and Specialized Centers of Research on Sex and Gender Factors Affecting Women's Health (SCOR). These programs benefit both women's and men's health through sex and gender research, interdisciplinary scientific collaboration, and provide tremendously important support for young investigators in a mentored environment.

The BIRCWH program is an innovative, trans-NIH career development program that provides protected research time for junior faculty by pairing them with senior investigators in an interdisciplinary mentored environment. What makes BIRCWH so unique is that it bridges advanced training with research independence across scientific disciplines. It is expected that each scholar's BIRCWH experience will culminate in becoming an established independent researcher in women's health. Since 2000, 197 scholars have been trained in the twenty-four centers recording over 634

publications and 526 abstracts. The scholars have secured forty NIH grants and seventy awards from industry and institutional sources.

The SCOR program, administered by the National Institute of Arthritis and Musculoskeletal and Skin Diseases, was developed by ORWH in 2001. SCOR's are designed to increase the transfer of basic research findings into clinical practice by housing laboratory and clinical studies under one roof. The program was designed to complement other federally supported programs addressing women's health issues such as BIRCWH. The eleven SCOR programs are conducting interdisciplinary research focused on major medical problems affecting women and comparing gender difference to health and disease. Each SCOR works hard to transfer their basic research findings into the clinical practice setting.

Despite the advancement of women's health research and its innovative programs, we were disappointed to see ORWH receive a $250,000 cut in fiscal year 2006 from the Office of the Director. Congress must direct NIH to continue its support of ORWH and its programs.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Department of Health and Human Services (HHS) has several offices that enhance the focus of the government on women's health research. Agencies with offices, advisors or coordinators for women's health or women's health research are the Department of HHS, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Agency for Healthcare Quality and Research, the Indian Health Service, the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services. These agencies need to be funded at levels adequate for them to perform their assigned missions. We ask that the Committee Report clarify that Congress supports these offices and would like to see them continued and strengthened in the coming fiscal year.

The focus on women's health within HHS has been critical to the advances made in women's health in getting the appropriate message out to patients and providers. Scientists have only just scratched the surface of understanding female biology, with new information forthcoming as a result of the recent sequencing of the human X chromosome. Now is the time to press ahead with this vital research to make discoveries and educate women about their health and clarify the misinformation they have been given for years and these offices are critical to the success of this effort. There are many important programs that we could identify from these women's health offices but we would like to specifically mention two in particular.

HHS OFFICE OF WOMEN'S HEALTH

The HHS Office of Women's Health (OWH) is the government's champion and focal point for women's health issues. It works to redress inequities in research, health care services, and education that have historically placed the health of women at risk. The OWH coordinates women's health efforts in HHS to eliminate disparities in health status and supports culturally sensitive educational programs that encourage women to take personal responsibility for their own health and wellness. An extraordinary program initiated by the OWH is the National Centers of Excellence in Women's Health (CoEs).

Developed in 1996, the CoEs offer a new model for university-based women's health care. Selected on a competitive basis, the current twenty CoEs throughout the country seek to improve the health of all women across the lifespan through the integration of comprehensive clinical health care, research, medical training, community outreach and public education, and medical school faculty leadership development. The CoEs are able to reach a more diverse population of women, including more women of color and women beyond their reproductive years. However, CoEs are vulnerable to pressures of obtaining adequate funding and having to compete for scarce resources. A CoE designation by the OWH is critical not only to patients and surrounding communities but also to establishing foundation and other non-government funding.

In fiscal year 2006 OWH received a decrease in its budget and the proposed fiscal year 2007 would flat fund the office. We urge Congress to provide an increase of $1.5 million for the HHS OWH to allow it to continue to sustain and expand the National Centers of Excellence in Women's Health.

AGENCY FOR HEALTHCARE AND RESEARCH QUALITY

The Agency for Healthcare Research and Quality (AHRQ) is the lead Public Health Service agency focused on health care quality, including coordination of all Federal quality improvement efforts and health services research. AHRQ's work

serves as a catalyst for change by promoting the results of research findings and incorporating those findings into improvements in the delivery and financing of health care. This important information provided by AHRQ is brought to the attention of policymakers, health care providers, and consumers who can make a difference in the quality of health care women receive.

AHRQ has a valuable role in improving health care for women. Through AHRQ's research projects and findings, lives have been saved and underserved populations have been treated. For example, women treated in emergency rooms are less likely to receive life-saving medication for a heart attack. AHRQ funded the development of two software tools, now standard features on hospital electrocardiograph machines that have improved diagnostic accuracy and dramatically increased the timely use of "clot-dissolving" medications in women having heart attacks.

While AHRQ has made great strides in women's health research, the Administration's budget for fiscal year 2007 could threaten life-saving research. If a budget request of $319 million were enacted, AHRQ would be flat funded for the third year in a row at fiscal year 2005 levels. Flat funding prior to application of taps by Congress seriously jeopardizes the research and quality improvement programs that Congress demands or mandates from AHRQ.

We encourage Congress to fund AHRQ at $443 million for fiscal year 2007. This will ensure that adequate resources are available for high priority research, including women's health care, gender-based analyses, Medicare, and health disparities.

In conclusion, Mr. Chairman, we thank you and this Committee for its strong record of support for medical and health services research and its unwavering commitment to the health of the Nation through its support of peer-reviewed research. We look forward to continuing to work with you to build a healthier future for all Americans.

PREPARED STATEMENT OF THE HUMANE SOCIETY OF THE UNITED STATES

On behalf of The Humane Society of the United States (HSUS) and our more than 9.5 million supporters nationwide, we appreciate the opportunity to provide testimony on our top funding priorities for the Labor, Health and Human Services, Education and Related Agencies Subcommittee in fiscal year 2007.

ALTERNATIVES TO ANIMAL TESTING

The ICCVAM Authorization Act (Public Law 106–545) requires Federal regulatory agencies to ensure that new and revised animal and alternative test methods be scientifically validated prior to recommending or requiring use by industry. The internationally agreed upon definition of validation, supported by the 15 Federal regulatory and research agencies that compose the ICCVAM, is: "the process by which the reliability and relevance of a procedure are established for a specific use."

Function of the ICCVAM

The ICCVAM performs an invaluable function by assessing the validation of new, revised and alternative toxicological test methods that have interagency application. After appropriate independent peer review, the ICCVAM recommends the test to the Federal regulatory agencies that regulate the particular endpoint test measures. In turn, the Federal agencies maintain their authority to incorporate the validated test methods as appropriate for the agencies' regulatory mandates. This streamlined approach of assessing the validation of test methods has reduced the regulatory burden of individual agencies; provided a "one-stop shop" for stakeholders for consideration of methods; and set uniform criteria for what constitutes a validated test method. The ICCVAM can also serve to appropriately assess test methods that can refine, reduce and replace the use of animals in toxicological testing.

The ICCVAM's representatives have rigorously assessed several test methods that are now deemed scientifically valid and acceptable. In addition, the ICCVAM is working to streamline assessment of methods from the European Union (EU) that have already been validated for use within the EU.

Request for Appropriations

Since passage of the "ICCVAM Authorization Act" in 2000, which makes the entity a permanent standing committee, NIEHS has provided between $1 and $2.6 million per fiscal year to NICEATM for ICCVAM's activities. In order to ensure that Federal regulatory agencies and their stakeholders benefit from the work of the ICCVAM, NIEHS funding is important. We respectfully request $4 million for this purpose in fiscal year 2007.

Request for Committee Report Language

The NIEHS should support the NICEATM/ICCVAM in creating a five-year roadmap for assertively setting goals to prioritize ending the use of antiquated animal tests for specific endpoints. It is also imperative that the ICCVAM take a more proactive role in isolating areas where new methods development is on the verge of replacing animal tests. These areas should form a collective call by the Federal agencies that compose the ICCVAM to fund any necessary additional effort that is required to eliminate the animal methods. We also strongly urge the NICEATM/ICCVAM to closely coordinate efforts with its European counterpart, the European Centre for the Validation of Alternative Methods (ECVAM), to ensure the best use of available funds and sound science and to ensure industry has a uniform approach to worldwide chemical safety evaluation.

We also respectfully request that the Committee consider including the following report language: "The Committee commends the National Interagency Center for the Evaluation of Alternative Methods/Interagency Coordinating Committee on the Validation of Alternative Methods (NICEATM/ICCVAM) for its leadership role in the assessment of new, revised and alternative scientifically validated methods for the Federal Government. The Committee also commends the National Toxicology Program (NTP) for finalizing its "Roadmap to Achieve the NTP Vision, A Toxicology Program for the 21st Century," which commits to "develop and validate improved testing methods and, where feasible, ensure that they reduce, refine or replace the use of animals" as one of its top four goals.

The Committee directs the NICEATM/ICCVAM, in partnership with the relevant Federal agency program offices and the NTP, to build on the NTP Roadmap to create a five-year plan to research, develop, translate and validate new and revised non-animal and other alternative assays for integration of relevant and reliable methods into the Federal agency testing programs. In this 5-year plan the Federal agency program offices shall be directed to identify areas of high priority for new and revised non-animal and alternative assays or batteries of those assays to create a path forward for the replacement, reduction and refinement of animal tests, when this is scientifically valid and appropriate. The Committee directs a transparent, public process for developing this plan and recommends the plan be presented to the Committee by November 15, 2007. Funding for developing the plan shall be from the NIEHS and the NTP, and shall not reduce the NICEATM/ICCVAM funding base."

BREEDING OF CHIMPANZEES FOR RESEARCH

The HSUS requests that no Federal funding be appropriated for breeding of chimpanzees for research, or for research that requires breeding of chimpanzees, for the following reasons:

—The United States currently has a surplus of chimpanzees available for use in research due to overzealous breeding for HIV research and subsequent findings that they are a poor HIV model.[1]

—The cost of maintaining chimpanzees in laboratories is exorbitant, totaling between and $9.3 million each year for the current population of 850 federally owned or supported chimpanzees ($15–30 per day per chimpanzee;[1] $500,000 per chimpanzee's 50-year lifetime).

—The National Center for Research Resources has a publicly-declared moratorium on breeding chimpanzees.

—Use of chimpanzees in research raises strong public concerns.

Background and history

Beginning in 1995, the National Research Council (NRC) confirmed a chimpanzee surplus and recommended a moratorium on breeding of federally owned or supported chimpanzees,[1] who now number approximately 850 of the 1,300 total chimpanzees available for research in the United States. According to a National Research Resources Advisory Council September 15, 2005 meeting, the National Center for Research Resources (NCRR) of NIH extended the moratorium until December 2007 because of high costs of chimpanzee care, lack of existing colony information, and failure of chimpanzees as an HIV model. There are, however, cases in which the moratorium is not being obeyed, prompting the need for Congressional action.

[1]NRC (National Research Council) (1997) Chimpanzees in research: strategies for their ethical care, management and use. National Academies Press: Washington, D.C.

Deviations from the moratorium

Despite the NCRR breeding moratorium, which prohibits breeding of federally owned or supported chimpanzee or NIH funding of projects that require chimpanzee breeding (NCRR written communication, February 28, 2006), chimpanzee breeding is still being funded by NIH. For example, the National Institute of Allergy and Infectious Diseases maintains a contract with New Iberia Research Center in Louisiana to provide 10 to 12 infant chimpanzees annually for research projects. The 10-year contract entitled "Leasing of chimpanzees for the conduct of research" has been allotted over $22 million, with $3.9 million awarded since its inception in September 2002.

Chimpanzees have often been a poor model for human health research

The scientific community recognizes that chimpanzees are poor models for HIV because chimpanzees do not develop AIDS. Similarly, though chimpanzees do not model the course of the human Hepatitis C virus, they continue to be widely used for this research. According to the chimpanzee genome, some of the greatest differences between chimpanzees and humans relate to the immune system,[2] calling into question the validity of infectious disease research using chimpanzees.

Ethical and public concerns about chimpanzee research

Chimpanzee research raises serious ethical issues, particularly because of their extremely close similarities to humans in terms of intelligence and emotions. Americans are clearly concerned about these issues: 90 percent believe it is unacceptable to confine chimpanzees individually in government-approved cages, and 54 percent believe that it is unacceptable for chimpanzees to "undergo research which causes them to suffer for human benefit" (conducted by Zogby International for Chimpanzee Collaboratory, 2001).

We respectfully request the following committee report language:

"The Committee directs that no funds provided in this Act be used to support the breeding of chimpanzees for research or to support research that requires breeding of chimpanzees."

PAIN AND DISTRESS RESEARCH

It is estimated that at least $10.2 billion per year of the current National Institutes of Health budget is devoted to some aspect of animal research.[3] At this time, no funding is set aside specifically for determination of ways to reduce the amount of pain and distress in animal research. Knowledge regarding recognition, assessment, and alleviation of animal pain and distress is critical for both the quality of scientific research and animal welfare.

NIH may receive $28.6 billion in fiscal year 2007 if Congress fulfills the President's budget request. Out of this funding, we seek $2.5 million (0.009 percent) for research and development focused on recognizing, assessing, and alleviating animal pain and distress in research. This is not a request for basic research on pain pathways or for application to the study of human pain, for example, but for the benefit of animals used in painful and distressful research.

In addition to our request for $2.5 million for this purpose, we also urge the Committee to specify in report language that this research should be conducted in conjunction with, or "piggy-backed" onto, ongoing research that already causes pain and distress. Infliction of pain and distress on additional animals is unnecessary, given the volume of existing research that is believed to involve moderate to significant pain and/or distress (we estimate a minimum of 20–25 percent of all animal research). Furthermore, it is expected that the amount of research that involves animal pain and distress will increase as animal use in biodefense research increases, as one example.

NIH has a statutory mandate to conduct or support research into alternative methods that produce less pain and distress in animals; this was specified in the NIH Revitalization Act of 1993 regarding a plan for the use of animals in research. Earmarked funding will assist NIH in meeting this mandate. Additionally, researchers themselves often comment publicly about the urgent need for funding in order to properly understand and mitigate pain and distress in research animals and to

[2] The Chimpanzee Sequencing and Analysis Consortium/Mikkelsen, TS, et al.,(1 September 2005) Initial sequence of the chimpanzee genome and comparison with the human genome, Nature 437, 69–87.

[3] NIH extramural funding accounts for approximately 90 percent of the NIH budget, or $25.5 billion. Of this, approximately 40 percent is devoted to some aspect of animal research—totaling approximately $10.2 billion. Intramural research also accounts for some animal research, but the exact figure is unknown.

follow Animal Welfare Act and Public Health Service policy requirements to minimize pain and distress.

It is well known that uncontrolled, undetected, and unalleviated pain and distress has adverse effects on animal welfare, which leads to adverse effects on the quality of science. Ultimately, the lack of information on pain and distress leads to misinterpretation of research results that could result in harmful effects in human beings when animal research results are applied to human clinical trials.

Numerous surveys indicate that concern about animal pain and distress strongly influences public opinion about animal research in general. For example, 75 percent of the American public opposes research that causes severe animal pain and/or distress, even when the goal of the research is to benefit human health (survey conducted by an independent polling firm for The HSUS, 2001).

Our Nation takes pride in leading the world in biomedical research, yet we lag behind many other countries in our efforts to minimize pain and distress in animal subjects. We urge the Committee to make this small investment of $2.5 million to promote animal welfare and enhance the integrity of scientific research. We also respectfully request this accompanying committee report language:

"The Committee provides $2.5 million to support research and development focused on improving methods for recognizing, assessing, and alleviating pain and distress in research animals. No pain and distress should be inflicted solely for the purpose of this initiative, since the investigations can and should be conducted in conjunction with ongoing research that is believed to involve pain and distress under Government Principle IV of Public Health Service Policy, which assumes that procedures that cause pain and distress in humans may cause pain and distress in animals."

Thank you for the opportunity to submit these requests on behalf of The Humane Society of the United States.

DEPARTMENT OF EDUCATION

PREPARED STATEMENT OF AMERICANS FOR THE ARTS

REQUEST

Americans for the Arts is pleased to submit testimony supporting fiscal year 2007 appropriations of $53 million for the Arts in Education program of the U.S. Department of Education (USDE). We call on the Senate Labor/HHS/ED Appropriations subcommittee to reject the severe cuts to the Corporation for Public Broadcasting and instead provide $430 million in fiscal year 2009. However, we support the President's request of $41.39 million for the Office of Museum Services within the Institute of Museum & Library Services (IMLS), also funded through this subcommittee.

Americans for the Arts is one of the leading national nonprofit organizations for advancing the arts and arts education in America. With a 45-year record of objective arts industry research, we are dedicated to representing and serving local communities and creating opportunities for every American to participate in and appreciate all forms of the arts.

ARTS EDUCATION

Our belief in the importance of practical research causes us to take special pleasure in supporting USDE's Arts in Education program, which is generating impressive evidence on the best ways to improve overall academic achievement by integrating the arts into the school curriculum.

As members of the subcommittee know, the Elementary and Secondary Education Act [20 USC 7271] provides that funding up to $15 million be directed to the John F. Kennedy Center for the Performing Arts and VSAarts. Prior to fiscal year 2001, funding never exceeded that level. Since fiscal year 2001, however, Congress has appropriated funding sufficient to support a broader array of arts education programs—for fiscal year 2006, Congress appropriated $35.6 million.[1] In addition to the Kennedy Center and VSAarts, USDE now supports grant competitions to further develop established arts education models and support professional development for arts educators in four arts disciplines.

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[1] This appropriation was reduced by a 1 percent across-the-board rescission to $35.3 million.

Three Reasons to Increase Arts Education Funding

Arts education works for children.—The most important reason to support arts education is simply stated: arts education works for children. Research increasingly confirms the beneficial effects of arts education in several areas, including but not limited to academic achievement. We refer the subcommittee to the research compendium Critical Links: Learning in the Arts and Student Academic and Social Development, released by the Arts Education Partnership in 2002, which includes 62 separate studies pointing to "critical links" between arts education and reading, writing, mathematics, cognitive skills, motivation, social behavior, and the school environment. The studies indicate that arts education is especially useful for students who are economically disadvantaged and/or in need of remedial instruction.[2]

Arts education provides training for a competitive workforce.—According to the 2002 National Governors Association publication The Impact of Arts Education on Workforce Preparation, "School districts are finding that the arts develop many skills applicable to the 'real world' environment. In a study of 91 school districts across the Nation, evaluators found that the arts contribute significantly to the creation of the flexible and adaptable workers that businesses demand to compete in today's economy."[3]

In addition, with more than 548,000 arts-centric businesses employing nearly three million people, arts education becomes a critical tool in fueling the creative industries of the future with arts-trained workers. Arts education is critical to the sustainability of an industry that comprises more than 4 percent of all U.S. businesses. We know from published research studies on the benefits of arts education that early learning in the arts nurtures the types of skills and brain development that are important for individuals working in the new economy of ideas.

In his State of the Union address this January, President Bush said "We must continue to lead the world in human talent and creativity." The arts are core to the development of creativity in our children. The arts develop skills and talents that foster imagination, critical thought, and teamwork: skills that are transferable to the workplace.

In the documentary "The Arts and Children: A Success Story," Dr. Sol Snyder—2003 recipient of the National Medal of Science and Distinguished Service Professor of Neuroscience, Pharmacology and Psychiatry at the Johns Hopkins University—said:

"In the arts, one trains one's senses to perceive and integrate what's going on either in the visual environment, auditory involvement, or even in the senses of smell, taste, and touch. The arts are very good for building those talents, those abilities. Sensory perception becomes quite important in mathematics, science, business.

"From my own background as a physician and research scientist, I have noticed that the most talented, the most productive people in the field are those who actually have a background in the arts because simple narrow scientific training is not enough to make major discoveries. The greatest scientists actually are artists in a sense. They are creative; they put together disparate things."[4]

A similar theme on the essential integration of the arts and innovation was mentioned in a recent New York Times column by Thomas Friedman when he wrote, "Innovation is often a synthesis of art and science, and the best innovators often combine the two." He went on to write that America's growing emphasis on math and reading must maintain a balance with creative learning in the arts to optimize human talent.[5]

There is solid research measuring how the arts are integrated into the classroom and how they boost achievement in math and science. Students who took four years of arts coursework outperformed those of their peers who had one half-year or less of arts coursework by 38 points on the math portion of the SAT. Students who include art in their studies are four times more likely to be recognized for academic achievement and four times more likely to participate in a math and science fair.

For example, the "Math in a Basket" program in the Long Beach, CA, school district—funded through a U.S. Department of Education Arts in Education Model Development & Dissemination grant—teaches students how to plan, design, and make baskets from scratch. Students become familiar with art concepts, measurement, algebraic formulas, and geometric concepts as they work with their baskets to find the surface area, perimeter, and volume of each basket. Participants in the "Math

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[2] http://www.aep-arts.org/CLhome.html.
[3] http://www.nga.org/Files/pdf/050102ARTSED.pdf.
[4] http://www.nasaa-arts.org/publications/artsandchildren.shtml.
[5] "Worried About India's and China's Booms? So Are They," Thomas Friedman, New York Times, March 24, 2006.

in a Basket" program score an average of 20 points higher than the control group on State math tests.[6]

Model programs are a wise investment.—Despite increases in overall Federal spending for K–12 education, evidence is beginning to accumulate that schools are neglecting those areas of the curriculum that are not subject to the mandatory testing requirements of No Child Left Behind (NCLB). The National Association of State Boards of Education (NASBE) identified the threat in its 2003 report "The Lost Curriculum."[7] In 2004, the Council for Basic Education released a survey of school principals in four States; one quarter of them reported that they have decreased instructional time in the arts.[8] This finding was confirmed just last month in the Center for Education Policy's (CEP) report "From the Capital to the Classroom: Year 4 of the No Child Left Behind Act," when it found that almost a quarter of school districts surveyed reported that time in science, art, and music had been reduced due to an increased emphasis on reading and math.[9] The CEP report recommends that USDE should promote "effective practices being used by school districts to enhance instruction in tested subjects without cutting time for other important subjects." The USDE arts education program is a wise investment in developing and disseminating these effective practices.

USDE Needs to Maintain Research Efforts in Arts Education

Meaningful research from USDE is needed to further determine the status of dance, music, theater, and visual arts education. The Fast Response Survey System (FRSS) report "Arts Education in Public Elementary and Secondary Schools" is the only research produced by USDE on the delivery of arts education and the last FRSS reported data collected in the 1999–2000 school year. The next round of data collection for an updated report is long overdue. We urge the subcommittee to direct USDE to execute the FRSS study as intended. Similarly, the National Assessment of Education Progress (NAEP)—the national arts "report card" last performed in 1997—is scheduled to be administered in 2008, and must stay on track. The next NAEP will provide critical information about the arts skills and knowledge of our Nation's students. Both of these quantitative studies are essential to studying and improving access to the arts as a core academic subject.

The Model Development & Dissemination program and the Professional Development program in the Arts in Education initiative at USDE receive targeted funding and are tested and measured in a limited number of implementation projects, and finally disseminated field-wide. This is a highly appropriate use of Federal dollars. Through this program, USDE promotes educational excellence, demonstrating how small projects can be brought to scale across entire school districts. Increased funding means more help for State and local departments of education to develop models that will work in highly disparate school districts across the Nation. We urge the Senate Subcommittee on Labor, Health and Human Services, and Education to recommend $53 million in funding for USDE's Arts in Education programs, with the bulk of the increase to be allocated to the Arts in Education Model Development and Dissemination Program and the Professional Development Program.

CORPORATION FOR PUBLIC BROADCASTING

We urge the subcommittee to reject the Administration's proposed funding cuts to the Corporation for Public Broadcasting (CPB) in the fiscal year 2007 Labor-HHS–Education appropriations bill. Any reduction in CPB's budget will drastically reduce the access that many Americans have to public broadcasting, and thus to high-quality arts and cultural programming.

CPB supports public television through its partner, the Public Broadcasting Service (PBS). A trusted community resource, PBS brings quality programs and education services to nearly 100 million people each week. With community-based arts programming and nationally televised shows, PBS is often the only source of arts programming in many rural parts of the country.

Public television airs arts programming that is not available on commercial television. For example, the Legends of Jazz television series on PBS marks the first time in 40 years that jazz has been the focus of a national network weekly series. Hosted by noted jazz pianist and radio personality Ramsey Lewis, the 13 weekly, 30-minute episodes debuted in June 2005 on PBS stations nationwide.

Budget cuts will weaken National Public Radio (NPR) stations and thus the availability of high-quality arts programming. Budget cuts will impact public radio

[6] http://www.dramaticresults.org/results.php.
[7] http://www.nasbe.org/Research__Projects/Lost__Curriculum.html.
[8] http://www.ecs.org/html/Document.asp?chouseid=5058.
[9] http://www.cep-dc.org/nclb/Year4/Press/.

broadcasting, as CPB funding represents an average of 13 percent of the budget for individual member stations of NPR. If NPR loses CPB support, many stations will have to make severe cuts to their programming and local services. This will especially impact rural areas and stations serving minority populations, as these stations heavily rely on Federal funding for their operating budgets. While local and State arts agencies also support these stations, they could not make up for a loss of Federal funding on this scale.

We join a broad coalition of public broadcasting supporters with this request for funding:

CPB General Appropriations—$430 million for fiscal year 2009
CPB Digital Funding—$40 million for fiscal year 2007
CPB Interconnection—$36 million for fiscal year 2007
Ready to Learn—$32 million for fiscal year 2007
Ready to Teach—$15 million for fiscal year 2007

INSTITUTE FOR MUSEUM & LIBRARY SERVICES

We urge the subcommittee to support no less than the President's proposed increase to $41.39 million for the Office of Museum Services within IMLS in the fiscal year 2007 Labor-HHS–Education appropriations bill.

IMLS encourages excellence and leverages State, local, and private funds. National competition is a catalyst for excellence and improves museum service nationwide. Federal leadership helps disseminate models and puts a spotlight on the remarkable resources that museums bring to education and to communities across the United States. In addition, peer-reviewed IMLS grants assure State, local, and private funders that a museum has met high national standards and is worthy of their additional support.

IMLS reinforces the role of museums in lifelong learning. Funding supports projects that address a full range of learning opportunities in museums, including developing exhibitions, working with schools to develop curriculum and programs, creating family and adult programs, and developing internet content. American museums provide over 18 million instructional hours to K–12 schoolchildren. Seventy-one percent work with school curriculum specialists to tailor programs to support local and State curriculum standards, according to the 2003 edition of the IMLS's report "True Needs, True Partners."

CONCLUSION

As the research cited above demonstrates, Federal funds boost the quality and quantity of support for arts education as well as the knowledge that can be gained and disseminated across the education establishment. Increased funding means more help for State departments of education, educators in schools, and local education agencies. Most importantly, it means a better education and more career opportunities for our children.

Americans for the Arts is the leading nonprofit organization for advancing the arts in America. With offices in Washington, DC, and New York City, it has a record of more than 45 years of service. Americans for the Arts is dedicated to representing and serving local communities and creating opportunities for every American to participate in and appreciate all forms of the arts. Additional information is available at www.AmericansForTheArts.org.

PREPARED STATEMENT OF THE AMERICAN GEOLOGICAL INSTITUTE

Thank you for this opportunity to provide the American Geological Institute's perspective on fiscal year 2007 appropriations for the Department of Education. The President's fiscal year 2007 request for the Department of Education places an emphasis on increasing U.S. competitiveness through math, science, and foreign language programs in keeping with the Administration's American Competitiveness Initiative announced in the President's State of the Union address. While $380 million is devoted to new funds for projects based on this initiative, these new funds would be offset by significant cuts to other programs within the Department of Education. The Department of Education budget would be reduced by $3.2 billion for a total requested budget of $54.4 billion. AGI strongly supports the President's initiative and in particular funding for improved science literacy for teachers and students, however, we do encourage the subcommittee to retain and provide support for other proven and effective programs.

The National Math and Science Partnership (MSP) program as part of No Child Left Behind effectively strengthens K–12 science and math education. The Presi-

dent's request includes $182 million for the MSP program within the Department of Education, which is the same level of funding appropriated in fiscal year 2006. AGI supports this stable funding and encourages appropriate emphasis on science education. Science often includes mathematical exercises applied to real-world problems, giving students a comprehensive and interesting learning experience.

The President's request for fiscal year 2007 focuses much new spending on math education and less on science education. Funding proposals based on the initiative include $125 million for Math Now for elementary school students and $125 million for Math Now for middle school students, plus an additional $10 million to create a National Math Panel to review and develop math curricula. While a solid math education is important, additional funding should also be devoted to science education, which complements and expands upon a mathematical foundation to understanding and exploring how physical, chemical and biological processes work.

It is essential that highly qualified science teachers develop the energetic, eager and curious next generation of scientists and engineers. Skilled geoscientists and geoengineers, in particular, are needed to find, develop and maintain our energy, agricultural, water and air resources, to understand and mitigate natural hazards and to ensure an educated public with a general understanding of the Earth environment to enhance our public and private quality of life.

AGI is a nonprofit federation of 44 geoscientific and professional societies representing more than 100,000 geologists, geophysicists, and other Earth scientists. Founded in 1948, AGI provides information services to geoscientists, serves as a voice for shared interests in our profession, plays a major role in strengthening geoscience education, and strives to increase public awareness of the vital role the geosciences play in society's use of resources and interaction with the environment.

In 1999, the Third International Math and Science Study found that the longer U.S. students are in school, the farther they fall behind in math and science proficiency in international comparisons. That prompted President Bush to propose the National Math and Science Partnership (MSP) program as part of No Child Left Behind. The goal of the partnership program is to strengthen K–12 science and math education by promoting a vision of education as a continuum that begins with the youngest learners and progresses through adulthood with teacher training. Among its activities, the program supports partnerships that unite K–12 schools, institutions of higher education and private industry.

Congress took the President's suggestion and authorized an MSP program at the National Science Foundation (NSF) and another partnership program at the Department of Education in 2002. These acts of Congress fund two different types of partnerships to achieve the overall goal of highly qualified math and science teachers ensuring that all students have the basic knowledge to compete in the ever changing and competitive job market. The funds allocated for the NSF's MSPs go to the highest quality proposals chosen through a competitive peer-reviewed grant program. The program focuses on modeling, testing and identification of effective math-science activities. The funds allocated for the Department of Education MSPs go directly to the States as formula grants, providing funds to all States to replicate and then implement the best of the NSF partnerships throughout the country. Once States receive the money, they make competitive grants to local partnerships.

The $120 million in funds for Secondary Education Mathematics Initiative is part of the overall High School Initiative, which will expand the application of No Child Left Behind principles to improve high school education and raise achievement, particularly the achievement of students most at risk of failure. This new initiative combines a number of categorical programs in order to give States and districts more flexibility and contains stronger accountability mechanisms.

AGI believes the two MSPs are the most effective approach to rapidly improving the abilities of all students to enhance their future prospects regardless of their ultimate career goals. The two programs, designed and authorized by Congress, are complementary. AGI supports funding at NSF for competitive grants for teaching tools and teacher training and funding at the Department of Education for formula grants for implementation of these tools in K–12 education. The peer-review process in the NSF program should be safeguarded as should the formula grants for all States as administered by the Department of Education. Moreover, the program within the Department of Education should not suffer a net reduction in funding in order to support a new initiative for mathematics. These funds should serve the Math and Science Partnership with no earmarks or set-asides.

Thank you for the opportunity to present this testimony to the subcommittee. If you would like any additional information, please contact me at 703–379–2480, ext. 228 voice, 703–379–7563 fax, rowan@agiweb.org, or 4220 King Street, Alexandria VA 22302–1502.

PREPARED STATEMENT OF THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

SUMMARY OF FISCAL YEAR 2007 RECOMMENDATIONS

—(1) $550 Million for HRSA's Health Professions Training Programs, Including:
  —$34 million for Minority Centers of Excellence.
  —$36 million for the Health Careers Opportunity Program.
  —$47 million for Scholarships for Disadvantaged Students.
—(2) $83 million for HRSA'S Healthy Communities Access Program.
—(3) 5 percent increase overall for the National Institutes of Health, including $250 million for the National Center on Minority Health and Health Disparities.
—(4) $119 million for the National Center for Research Resources Extramural Facilities Construction Program.
—(5) $65 million for the Department of Education's Strengthening Historically Black Graduate Institutions Program.
—(6) $65 million for the HHS Office of Minority Health, including support for a new health disparities initiative.

Mr. Chairman, thank you for the opportunity to present the views of the Association of Minority Health Professions Schools (AMHPS). I am Dr. Wayne Harris, Dean of the College of Pharmacy at the Xavier University of Louisiana.

AMHPS is comprised of the Nation's twelve historically black medical, dental, pharmacy, and veterinary schools. Combined, our institutions have graduated 50 percent of African-American physicians and dentists, 60 percent of all the Nation's African-American pharmacists, and 75 percent of the African-American veterinarians.

Mr. Chairman, historically black health professions institutions are addressing a pressing national need in carrying out their mission of training minorities in the health professions. While African-Americans represent approximately 15 percent of the U.S. population, only 2–3 percent of the Nation's health professions workforce is African-American. Studies have demonstrated that when African Americans and other minorities are trained in minority institutions, they are much more likely to: (1) serve in medically underserved areas, (2) care for minorities, and (3) accept patients who are Medicaid dependent or otherwise poor.

This is important Mr. Chairman because the gap in health status between our Nation's minority and majority populations continues to widen due in part to the lack of access to quality health care services in minority communities. As a result, we believe it is imperative that the Federal commitment to training African Americans and other minorities in the health professions remains strong.

In spite of our proven success in training health professionals, and the important contribution these professionals make, our institutions continue to face a financial struggle inherent to our mission. The financial challenges facing the majority of our students affect our institutions in numerous ways. For example, we are unable to depend on tuition as a means by which to respond to any discontinuation of Federal support. Moreover, the patient populations served by the AMHPS institutions are overwhelmingly poor. As a result, our institutions cannot rely on patient care income at a time when the average medical school gets 40–60 percent of its operating revenue from health care services.

Mr. Chairman, before I go into a discussion of our Association's fiscal year 2007 recommendations, I would like to share Xavier's experience with Hurricane Katrina and update you on our recovery efforts. Xavier is located in New Orleans and the entire campus was flooded with 3–6 feet of water. Each building on campus had significant damage on the first floor and the campus was shut down until January 9, 2006. The University developed an ambitious plan to repair damage and resume operations on January 17, 2006 using a revised academic calendar to complete the entire academic year in August 2006. I am happy to report that the University resumed classes on January 17 as planned. Overall University enrollment dropped, however, from approximately 4,000 students in August 2005 to approximately 3,000 students post-Katrina. The College of Pharmacy enrollment was less severely affected with enrollment dropping from 619 to 600.

Significant challenges still remain, including cash flow problems as we deal with recovery costs in the range of $30 million for construction and equipment and disruption of operations of key health care institutions in New Orleans. These institutions are vital to the clinical education program of the College of Pharmacy and to our continued recovery. It is absolutely essential to the University that health care delivery services are restored as quickly as possible.

The University recognized the need to resume our academic programs as quickly as possible in order to continue to produce African American health professionals and contribute to rebuilding the City of New Orleans. By working with other Colleges of Pharmacy across the country, we were able to allow senior pharmacy students to continue their clinical education while under evacuation and we are pleased to report that pharmacy students will graduate on May 20, 2006. Our rebuilding effort is well underway but disruption of Federal support for important programs such as HRSA'S Center of Excellence would severely hinder this rebuilding effort.

FISCAL YEAR 2007 RECOMMENDATIONS FOR FEDERAL PROGRAMS OF INTEREST TO AMHPS

Health Resources and Services Administration

Health Professions Training

Mr. Chairman, we are disappointed that the President's budget all but eliminates funding again this year for health professions training programs focused on diversity in the workforce. The health professions training programs administered by the Health Resources and Services Administration are the only Federal initiatives designed to address the longstanding under-representation of minority individuals in health careers. HRSA's Minority Centers of Excellence, Health Careers Opportunity Program, and Scholarships for Disadvantaged Students, support health professions institutions with a historic mission and commitment to increasing the number of minorities in the health professions. For fiscal year 2007, AMHPS joins with the Health Professions Nursing and Education Coalition in recommending an overall funding level of $550 million for health professions training.

For the health professions programs specifically focused on enhancing minority representation in the health care workforce, AMHPS recommendations are as follows:

Minority Centers of Excellence

The purpose of the Minority Centers of Excellence program (COE) is to assist schools that train minority health professionals by supporting programs of excellence in health professions education at those institutions. The COE program focuses on improving student recruitment and performance; improving curricula and cultural competence of graduates; facilitating faculty/student research on minority health issues; and training students to provide health services to minority individuals by providing clinical teaching at community-based health facilities. For fiscal year 2007, AMHPS recommends a funding level of $34 million for Minority Centers of Excellence (an increase of $22 million over fiscal year 2006).

Health Careers Opportunity Program

Grants made to health professions schools and educational entities under the Health Careers Opportunity Program (HCOP) enhance the ability of individuals from disadvantaged backgrounds to improve their competitiveness to enter and graduate from health professions schools. HCOP funds activities that are designed to develop a more competitive applicant pool through partnerships with institutions of higher education, school districts, and other community based entities. HCOP also provides for mentoring, counseling. primary care exposure activities and information regarding careers in a primary care discipline. Sources of financial aid are provided to students as well as assistance in entering into the health professions school.

For fiscal year 2007, AMHPS recommends a funding level of $36 million for the Health Careers and Opportunities Program (an increase of $32 million over fiscal year 2006).

Scholarships for Disadvantaged Students

The Scholarships for Disadvantaged Students program was established to make scholarship funds available to eligible students from disadvantaged backgrounds who are enrolled (or accepted for enrollment) as full-time students. To be eligible for funding, a school must have in place a program to recruit and retain students from disadvantaged backgrounds (including racial and ethnic minorities) and demonstrate that the program has achieved success based on the number or percentage of disadvantaged students who graduate from the school. For fiscal year 2007, AMHPS recommends a funding level of $47 million for the Scholarships for Disadvantaged Students program (an increase of $47 million over fiscal year 2007).

Healthy Communities Access Program

Mr. Chairman, Congress passed legislation in 2003 to reauthorize the Community Health Centers program. Included in this important measure was a provision which established a demonstration authority within the Healthy Community Access Pro-

gram to foster greater collaboration between historically black health professions and federally qualified CHC's. Specifically, this provision:

(1) Establishes a demonstration program for the development of research infrastructure at historically black health professions schools affiliated with federally qualified Community Health Centers.

(2) Establishes joint and collaborative programs of medical research and data collection between historically black health professions schools and federally qualified Community Health Centers with the goal of improving the health status of medically underserved populations.

(3) Supports the cost of patient care, data collection, and academic training resulting from these partnerships.

Mr. Chairman, several of our member institutions received funding in fiscal year 2005 under this promising new demonstration authority. Unfortunately, the H–CAP program was eliminated in the fiscal year 2006 Labor-HHS bill, and the President's budget for fiscal year 2007 does not provide any funding for the coming year. AMHPS encourages the subcommittee to restore support for this important program in fiscal year 2007 at the fiscal year 2005 level of $83 million.

National Institutes of Health

The National Center on Minority Health and Health Disparities

Established in 2000 by the Minority Health and Health Disparities Research and Education Act (Public Law 106–525), the National Center on Minority Health and Health Disparities at NIH is charged with addressing the longstanding health status gap between minority and majority populations. The National Center has the authority to:

—Directly support biomedical research, training, and information dissemination focused on eliminating health status disparities.

—Serve in a leadership capacity in developing a comprehensive plan for minority health research at NIH.

—Participate as an equal when NIH institute and center directors meet to determine research policy.

—Support the enhancement of biomedical research capacity at minority health professions institutions through a "Research Endowment" program.

—Support the development of health professions institutions with a history and mission of serving minority and medically underserved communities through a "Centers of Excellence" program.

For fiscal year 2006, AMHPS recommends a funding level of $250 million for the National Center. This is an increase of $54 million. This new funding will enable the Center to support all of its new programs and begin to meet the challenge of eliminating health status disparities within minority and medically underserved communities

Extramural Facilities Construction

Mr. Chairman, if we are to take full advantage of the historic funding increases for biomedical research that Congress has provided to NIH over the past decade, it is critical that our Nation's research infrastructure remain strong. The current authorization level for the Extramural Facility Construction program at the National Center for Research Resources is $250 million. The law also includes a 25 percent set-aside for "Institutions of Emerging Excellence" (many of which are minority institutions) for funding up to $50 million. Finally, the law allows the NCRR Director to waive the matching requirement for institutions participating in the program. We strongly support all of these provisions of the authorizing legislation.

Unfortunately, funding for NCRR's Extramural Facility Construction program was completely eliminated in the fiscal year 2006 Labor-HHS bill. For fiscal year 2007, AMHPS encourages the subcommittee to restore funding for this program to its fiscal year 2004 level of $119 million, or at a minimum, provide funding equal to the fiscal year 2005 appropriation of $40 million.

Research Centers in Minority Institutions

The Research Centers at Minority Institutions program (RCMI) at the National Center for Research Resources has a long and distinguished record of helping our institutions develop the research infrastructure necessary to be leaders in the area of health disparities research. Although NIH has received unprecedented budget increases in recent years, funding for the RCMI program has not increased by the same rate. Therefore, AMHPS recommends that funding for this important program grow at the same rate as NIH overall in fiscal year 2007.

Strengthening Historically Black Graduate Institutions—Department of Education

The Department of Education's Strengthening Historically Black Graduate Institutions program (Title III, Part B, Section 326) is extremely important to AMHPS institutions. The funding from this program is used to enhance educational capabilities, establish and strengthen program development offices, initiate endowment campaigns, and support numerous other institutional development activities. For fiscal year 2007, AMHPS recommends an appropriation of $65 million (an increase of $7 million over fiscal year 2006) to continue the vital support that this program provides to historically black graduate institutions.

HHS Office of Minority Health

The HHS Office of Minority Health (OMH) has the potential to play a critical role in addressing health status disparities throughout the country. Unfortunately, the office does not currently have the authority or resources necessary to support activities that will truly make a difference in closing the health gap between minority and majority populations. For fiscal year 2007, AMHPS recommends a funding level of $65 million for the Office, with $10 million designated for the following programs focused on medically underserved communities and capacity building for the training of minorities in health professions:

(1) OMH sponsored programs to assist medically underserved communities with the greatest need in solving health disparities and attracting and retaining health professionals;

(2) Assistance to minority institutions in acquiring real property to expand their campuses to increase the capacity to train minorities for medical careers;

(3) Support of conferences for high school and undergraduate students to pursue health professions careers; and

(4) Support for cooperative agreements with minority institutions for the purpose of strengthening their capacity to train more minorities in the health professions.

Once again, thank you for the opportunity to present the views of the Association of Minority Health Professions Schools. We look forward to working with you in support of these important programs.

PREPARED STATEMENT OF THE CENTER FOR EDUCATION

EXECUTIVE SUMMARY

The Department of Education's (ED) justification for eliminating funding for the Education for Democracy Act is essentially the same as it was for fiscal year 2006. It also includes the same omissions and errors, as noted in the following response.

The Center for Civic Education (Center) and others supported under the Act believe the three major findings of the ED report are not adequately supported by the facts. Brief responses to the three findings are presented here. More detailed responses follow.

1. "Limited impact." The first paragraph of the ED justification for eliminating the Civic Education program states that it is "eliminating small categorical programs that have limited impact. . . ." The statement appears to be contradicted in the next paragraph which recognizes the extent of the Center's programs: "Districts in nearly every State and major urban area participate in We the People program activities."

The Center's programs provide sound, sustained, and effective instruction in the fundamental values and principles of constitutional democracy annually to approximately 3 million domestic students and 2 million students in other nations at a cost of approximately $5–6 per student. Research and evaluation have demonstrated the significant impact of these programs that provide a cost-effective means of reaching a significant number of students. Since its inception, the Center's We the People program alone has reached more than 28 million students in the United States.

2. "Little or no reliable evidence of effectiveness." The ED justification fails to cite or recognize the extensive research and evaluation of Center programs as well as other significant evidence of program effectiveness, none of which is matched by any other program in the field.

3. "Additional funding is not necessary for the successful operation of this program." To anyone aware of the history of support for civic education, and the policies, priorities, and practices of private sector funding, it is clear that support for national and international programs in civic education of the magnitude of those implemented by the Center is simply not available from sources other than the Federal Government. Federal funding is essential for the continuation of this program.

The following information provides a more detailed response to the ED report.

INTRODUCTION

The Department of Education's (ED) justification for eliminating funding for the Education for Democracy Act is essentially the same as it was for fiscal year 2006. It also includes the same omissions and errors as will be noted in the following response.

ED's justification is composed of three major parts: that the Civic Education programs supported under the act (1) have "limited impact," (2) have "little or no reliable evidence of effectiveness," and that (3) "additional funding is not necessary for the successful operation of this program." The Center for Civic Education (Center) and others supported under the Act believe these findings are not adequately supported by the facts. The Center's responses follow.

1. Response: The Civic Education program has "limited impact"

The first paragraph of the ED justification for eliminating the Civic Education program states that ED is "eliminating small categorical programs that have limited impact. . . ." In the next paragraph it states that "The Center . . . is an established non-profit organization with a broad network of program participants, alumni, volunteers, and financial supporters at the local, state, and national levels. Districts in nearly every State and major urban area participate in We the People program activities." It is difficult to square the first statement with the second, because for a relatively small amount of Federal funds, the Center's domestic and international programs have a significant impact on the education of students at the precollegiate level as well as their teachers in the United States and abroad. The following information supports this premise.

The fiscal year 2006 appropriation for the Education for Democracy Act is $29.1 million. In round figures, the allocation of these funds is as follows:

—Center for Civic Education (directed funding)
—Domestic programs = $17 million
—International programs = $4.5 million
—National Council for Economic Education (directed funding)
—International program = $4.5 million
—Competitive international exchange program = $3.1 million
—Note: The Center currently has a $1 million grant under this program for Latin America and a $1 million grant for Africa

Impact of the Center's Domestic Programs

Approximately 70 percent of the Center's $17 million for domestic programs is allocated to public- and private-sector institutions or organizations at State and local levels in the form of sub-awards, free curricular materials, and subsidized teacher training programs. These funds are managed by approximately 120 coordinators located in public or private sector agencies or organizations at State levels. They are assisted by approximately 630 congressional district coordinators, many of whom are affiliated with school districts. These coordinators, essentially volunteers, receive a modest stipend to cover operating costs. These coordinators in turn coordinate thousands of additional volunteers who serve as judges, academic coaches, timers, facilitators, and in other roles required by the size and scope of this endeavor. The value of this volunteer network greatly amplifies the value of the Federal investment and the reach of the program and exemplifies American civic virtue in action. The remaining 30 percent of the funds pays for technical assistance to this network and the administrative operating costs of the Center.

The domestic network of coordinators oversees the implementation of three major curricular programs that reach approximately 3 million students annually at a cost of approximately $5.67 per student. For this sum, each student receives the use of a free textbook and an estimated 10 to 40 or more hours of instruction in the fundamental values and principles of American constitutional democracy and how to participate competently and responsibly in political life. As noted below, ample research testifies to the positive outcomes of these programs.

The Department of Education's rationale for cutting the Civic Education program claims that its "contribution to the Department's mission is marginal." This statement does not seem to be in line with the policy of President Bush, who stressed the importance of civic education in the 2002 introduction to his initiative in History, Civics, and Service, in which he stated that:

"American children are not born knowing what they should cherish—are not born knowing why they should cherish American values. A love of democratic principles must be taught. At this very moment, Americans are fighting in foreign lands for principles defined at our founding, and every American—particularly every American child—should fully understand these principles."

The question might be asked: What other programs in civic education does ED support, if any, that accomplish the mission set forth in President Bush's speech and which, if any, have the impact on students per Federal dollar that result from programs supported under the Education for Democracy Act? It should be noted that the Federal funding for this program is matched by cost sharing at State and local levels estimated at from $5–$8 in value for every Federal dollar spent.

The need for improvement in the civic education of our Nation's students has been demonstrated repeatedly by research findings over the past several decades. This need was clearly illustrated in a recent survey in which only 28 percent of Americans could list two or more First Amendment freedoms, while more than 50 percent could name at least two cartoon characters from "The Simpsons" (McCormick Tribune Freedom Museum Poll, March 1, 2006). The programs supported by Congress under the Education for Democracy Act are a proven cost-effective means of remedying this shortcoming in the education of our Nation's youth.

Impact of the Center's International Programs

As with its domestic programs, approximately 70 percent or more of the Center's international funding is allocated to public- and private-sector institutions or organizations at State and local levels in the United States and similar organizations in approximately 70 emerging and advanced democracies throughout the world. This support is provided in the form of sub-awards, free curricular materials, and subsidized teacher training programs. These funds are managed by public- and private-sector organizations in 28 States and similar organizations in the participating countries. The remaining 30 percent of the funds pay for technical assistance to this network and the administrative operating costs of the Center.

The international network of coordinators oversees the implementation of curricular programs focused on education for democracy. It is difficult in many cases to get accurate figures on participation in these programs from the participating countries. We believe that 2 million students per year is a modest estimate. The students in these countries are being provided instruction in the fundamental values and principles of constitutional democracy and how to participate competently and responsibly in political life. As noted below, ample research testifies to the positive outcomes of these programs.

The $4.5 million in baseline funding for this program from ED is augmented by approximately $8 million more in grants from ED, the Department of State, USAID, and other domestic sources. The program has also precipitated funding from other sources of approximately $15 million to augment its impact. These sources include the European Union, the Russian Ministry of Education, the InterAmerican Development Bank, the World Bank, the Mexican Institute for Federal Elections, and other public- and private-sector sources in other countries. This additional support could not have been generated without the funding from ED that has served as "seed" money for the establishment of successful education for democracy programs in other nations.

The impact and success of these programs is supported by research findings and numerous reports from U.S. Embassies and AID missions, which have assisted the Center in their establishment. In many cases, the successful impact of pilot programs supported by ED funds has prompted these entities to add their own funds to augment the programs. A notable example of such an occurrence was the Center's ED-supported Jordanian pilot program in democracy education, which has received approval for nationwide implementation by the Ministry of Education. The success of this program led the State Department to provide an additional $3.2 million to implement democracy education programs in ten Arab nations in North Africa and the Middle East. In turn, the success of that program led the State Department to request that the Center submit a proposal for three years of funding for the region at $3–4 million per year. None of this would have been possible without the sustained funding from ED that enables the Center to initiate and maintain education for democracy programs in spite of the changing priorities of other sources of funding. It is important to note that the State Department funding does not eliminate the need for the baseline ED funding for the international civic education program and that with continued ED funding, similar advances might be made in other parts of the world.

It is clear that these programs are a significant and cost-effective contribution to the administration's effort to further the worldwide growth of democracy, which is why President Bush has met with the Center's Russian partner, and Secretary of State Condolleeza Rice has met with the Center's partner in Pakistan. It is also clear that the international civic education for democracy movement, central to the administration's foreign policy, is at risk without significant continuing funding. Although a fledgling nongovernmental membership organization—Civitas Inter-

national—was founded by the United States Information Agency in 1995 to assist efforts in this field, the organization was never able to raise sustaining funds from other organizations or individuals that would permit it to function independently. Instead, the organization asked the Center to assist it by folding its meetings and functions into the Center's civic education network.

Note: In addition to those students reached by the Center's international programs, the economics program funded under this Act and implemented by the National Council for Economic Education reaches an estimated 2.4 million students annually. The goal of this effective program is to help students understand the principles and institutions of market economies and their relationship to democracy.

Summary

Contrary to the Department of Education's assertion in its justification for eliminating funding for the Education for Democracy Act, the Center's programs have a significant impact on the civic education of pre-collegiate students and their teachers in the United States and abroad.

The Center's programs are proven, cost effective, and reach millions of students throughout the world. Approximately 3 million students in the United States benefit from the Center's curricular programs at a cost of approximately $5.67 per student. The Center's programs directly contribute to the mission of the Department of Education by accomplishing the mission set forth in President Bush's initiative in History, Civics, and Service.

Approximately 2 million students per year outside of the United States are provided by the Center and its network of coordinators with instruction in the fundamental values and principles of constitutional democracy and learn how to participate competently and responsibly in political life. Funding provided by the Department of Education is essential for the establishment of successful education for democracy programs in other nations. The spectacular success of Center initiatives in Jordan and other Arab nations demonstrates the Center's cost-effective contribution to the Bush administration's effort to advance the worldwide growth of democracy.

2. Response: There is "little or no reliable evidence of [the] effectiveness" of the Center's programs

The Department's document claims that studies of the programs of the Center are not sufficiently rigorous to yield reliable results about their overall effectiveness. To that end, a single study conducted by the Center on students participating in the national finals of the Center's annual We the People competition was cited. The study employs nationally normed items from the National Assessment of Educational Progress (NAEP), the National Election Studies, and the College Freshman surveys. The positive results of this study were challenged by ED because the students were a select sample—even though that fact had always been clearly identified and understood as such, and the Department accepted it as a valid performance indicator. Indeed, the study in question is performed annually in partial fulfillment of requirements placed on the Center by the Department of Education.

Since its inception in 1965 at the University of California at Los Angeles, the Center has conducted numerous studies on the effectiveness of its curricular programs and contracted with third parties that have also conducted such studies. (Most of these studies are not referred to in the ED report.) Indeed, the We the People programs have been more thoroughly researched than any other programs in the field.

Each of the recent studies cited below falls within the recommendations of the What Works Clearinghouse at the Institute of Educational Sciences (IES) of the Department of Education. IES encourages the methodological rigor of studies that include experimental or high-quality quasi-experimental design and cites them as the best determinants for measuring curricular effectiveness.

Study: MPR Associates, Inc.— A high-quality quasi-experimental study of the We the People: The Citizen and the Constitution program conducted in 2003 by MPR Associates, Inc., in collaboration with noted research scholars Dr. Richard Niemi, University of Rochester, and Dr. Elizabeth Theiss-Morse, University of Nebraska-Lincoln, found statistically significant differences between We the People and non-We the People students. Specifically, We the People students enrolled in AP classes performed, on average, 30 percent better on the knowledge survey than students enrolled in non-We the People AP classes. We the People students in regular classrooms also significantly outperformed their non-We the People counterparts.

The study also found that We the People students were more likely than their peers to show greater growth in their sense of political efficacy, sense of citizen responsibility, appreciation of obligations of citizenship, and a greater sense of political and community responsibility than the control group. The results of these studies show the degree to which the Center's programs meet President Bush's request

for civic education initiatives that "improve students' knowledge of American history, increase civic involvement, and deepen their love for our great country." (Bush 2002, 1)[1] It should be noted that the Center was unable to obtain funding for a proposal submitted to the Department of Education in 2005 for a study employing random assignment of students to the curriculum. The Center is still seeking funds to use the instruments it has developed to conduct a longitudinal study over seven years.

Study: University of Texas.—Dr. Kenneth Tolo, University of Texas at Austin, found that the Center's We the People: Project Citizen program had positive effects on student attitudes and skills, including students' attitudes about their own effectiveness and their engagement in their communities. The program also enhanced student communication and research skills.

The study also details seven key areas of Project Citizen implementation—State administration, the recruitment of and outreach to teachers and school administrators, teacher training, teacher and class use, Project Citizen competitions, benefits to students, and financial and political support—and offers recommendations for maximizing implementation efforts in each of these areas. These recommendations have been invaluable to improving the implementation strategies of Project Citizen in the United States and abroad.

Study: RMC Research.—In 2004–2005, RMC Research used qualitative and quantitative measures in a quasi-experimental study of students taking part in the Project Citizen program in Oklahoma, Michigan, Colorado, the Czech Republic, and Slovakia. The study found that students in grades 6–12 increased their global knowledge of democracy. The study found significant gains in students' knowledge of public policy, support for freedom of belief, the right of citizens to question government messages, and the right to join organizations. Students' civic skills improved as well. Based upon these results, RMC is improving item reliability and will conduct a second study in 2006.

Study: Indiana University at Bloomington.—A high-quality quasi-experimental study of students in Indiana, Latvia, and Lithuania by Thomas S. Vontz, Kim K. Metcalf, and John J. Patrick, Indiana University at Bloomington, found that We the People: Project Citizen develops students' civic knowledge, skills, and dispositions positively and significantly, irrespective of nationality. The full report has been published in a volume titled Project Citizen and the Civic Development of Adolescent Students in Indiana, Latvia, and Lithuania.

Study: Center for Civic Education, Bosnia and Herzegovina.—A high-quality quasi-experimental study of students in Bosnia and Herzegovina in 2000 by Dr. Suzanne Soule, Center for Civic Education, found that Project Citizen students showed greater confidence in their knowledge of local government, were more skilled at explaining problems; showed greater analytical abilities in using facts and reason to analyze other people's positions on problems, had more positive attitudes with regard to their own power in the community and internal efficacy, and showed a greater propensity to hold public officials accountable. In 2002, First Lady Laura Bush praised the program in remarks to the Organization for Economic Cooperation and Development:

"The United States is also a partner in the Balkans, working with the International Community and Civitas in Bosnia and Herzegovina to develop a course in democracy and human rights. This course is taught in (primary) schools throughout the region, including Brcko, and it has been translated for all three ethnic groups. The course is part of a larger effort called 'Project Citizen.' Through 'Project Citizen' programs, children learn to identify and solve problems in their own communities, from supplying clean water to improving dangerous traffic crossings. Citizenship—a sense of belonging and responsibility—strengthens societies."

Study: Center for Civic Education, Indonesia.—A high-quality quasi-experimental study of students in Indonesia in 2002 by Dr. Suzanne Soule found Project Citizen participants' political participation increased as a result of their involvement with the program. In contrast to the control group, they participated more in the political process, conducted more research by contacting experts to obtain information on issues they cared about, and participated in protests at higher rates. They also paid more attention to public affairs in the media. The dispositions of students who participated more fully in the program—by selecting their problems, presenting their proposals, and engaging in other programmatic activities—changed more. They became more interested in politics and public affairs. Their confidence in their ability

[1] Bush, George W. (2002). "President Introduces History and Civic Education Initiatives." Remarks of the president on the Teaching History and Civic Education Initiative, September 17. www.whitehouse.gov.

to participate, along with their sense of political efficacy, increased. Further, high-involvement participants increased their expectations of the proper responsiveness of government, an important component of accountability.

Study: WestEd.—The Center is currently working with WestEd, a leading survey-design firm, to devise knowledge and attitude tests for We the People: Project Citizen domestic and international use. The standardized test will be refined and used within and outside the United States with various quasi-experimental and experimental studies to ensure a maximum scale of comparability. The knowledge tests have been piloted in Nigeria and South Africa and are to be utilized in an experimental study in Colombia and Mexico in 2006.

State Department Report.—In a report released by the State Department's Bureau of Western Hemisphere Affairs, the Center's ED-supported Civitas Latin America program is presented as a model for developing Cuban democracy (see Chapters 2 and 3). The report cites success in training teachers and effectiveness of programs as important for encouraging democratic thought and practice.

USAID Report.—The State Department report is in accord with an independent assessment of civic education programs funded by USAID from 1990 to 2000, which found that "We the People: Project Citizen has many of the characteristics of the most effective civic education programs. It is highly participatory, it relates to issues that affect the participants in their daily lives, it produces tangible as well as intangible results, and it is firmly rooted in the community in which it takes place." (Brilliant, 2000, 38).[2]

Other Evidence of the Effectiveness of the Center's Programs

In addition to previous references to visits with program participants by President Bush, Mrs. Bush, and Secretary Rice, the obvious effectiveness of the Center's programs has been recognized at other times at the highest levels of government in the United States and other nations. For example:

—In 1996, the Supreme Court hosted the newly elected U.S. Senate in the Great Hall of the Court. The event was attended by seven Justices and more than ninety senators. The major attraction of the evening was a well-received demonstration of the We the People competitive hearing by students from the State of Oregon.

—In 1998, students from the We the People program were honored by the Department of Education when Secretary Riley announced the release of the findings of the NAEP study of student knowledge of civics and government.

—In 2000, We the People students were invited to testify in Congress on the subject of school violence. Members of the committee before which the students testified said that they were better prepared than many of the expert witnesses who had testified earlier.

—In 2004, the Bush administration hosted a White House Conference on History, Civics, and Service. The only civics program featured was the We the People program. Students from Arizona demonstrated their outstanding knowledge of the U.S. Constitution and Bill of Rights before a panel composed of a noted scholar and two Federal judges. One of the Federal judges commented that the students had a firmer grasp of constitutional principles than most attorneys who appear in her court.

—In 2005, the Department of Education invited teachers of the We the People program to speak to a Constitution Day assembly at the Department, at which they were extremely well received.

—Other nations: The following are a few of the many incidences where other nations have recognized the quality and effectiveness of the Center's programs:

—The Russian Ministry of Education has approved the use of the Center's We the People and Project Citizen texts in all Russian schools.

—The Mexican Institute for Federal Elections has translated and adapted the Project Citizen text and is implementing it in classrooms in all States of Mexico.

—The Center has helped the U.S. Embassy in Bosnia and Herzegovina develop a K–12 civic education program that is being implemented in all schools in that country.

—The Jordanian Ministry of Education has approved the implementation of Project Citizen in all schools in Jordan.

—The Kurdish Regional Authority in Iraq has translated and adapted the Center's Foundations of Democracy program and implemented it with more that 400,000 students in their region.

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[2] Brilliant, F. (2000). Civic Education Assessment—Stage II. Civic Education Programming Since 1990—A Case Study Based Analysis. Report for the U.S. Agency for International Development.

—The U.S. Embassy in Baghdad recently supported the training of teacher trainers in the Center's curricular materials and intends to support their implementation throughout the country.
—The textbook division of the Chinese Ministry of Education has translated and adapted material from the Center's texts to be used in schools throughout China. The division has also signed a memorandum of understanding with the Center to work together to develop more curricular materials.

Summary.—The following generalizations can be made from internal and external research and evaluation studies conducted during the past seventeen years. Students who participate in the Center's curricular programs show the following results. In comparison with their peers and some adults, students in Center programs:

—demonstrate a greater understanding of and commitment to fundamental values and principles of constitutional democracy, such as individual rights, the common good, the rule of law, and civic responsibility. They are also less cynical, more politically engaged, more politically tolerant, and think that they can and do make a difference in the political life of their communities and nations;
—demonstrate a greater understanding of politics and government at local, intermediate, and national levels and a deeper knowledge of how to participate effectively in the political process;
—possess better research, analytic, and communication skills. This includes an increased capacity to evaluate, take, and defend positions on public issues;
—demonstrate a greater capacity to work with others to effectively monitor and influence the decisions of their government;
—pay more attention to politics and the media, discuss politics more often, volunteer to work for candidates, register to vote, and vote at significantly higher rates than their peers. Students also take active roles in the enactment of policies to improve the life of their communities and nations.

Please see the attached bibliography for a list of studies conducted on Center programs.

3. Response: "Additional funding is not necessary for the successful operation of this program"

The Department's justification claims that "additional funding is not necessary for the continuation of this program." Further, the Department asserts that:

"[the] Center also has a long history of success raising additional funding support through such vehicles as selling program-related curricular materials, trainings, and workshops, partnering with non-profit groups on core activities, lobbying, and seeking support from foundations. For example, the Center has received financial support from such organizations as the Pew Charitable Trusts, the National Endowment for the Humanities, the Joyce Mertz-Gilmore Foundation, the Lincoln and Therese Filene Foundation, Inc., and an increasing number of State and local entities. Also with a national board that includes . . . noted scholars (etc.), the Center will have many opportunities to generate additional support for core program activities."

The statements in this section of the report do not reflect a sound knowledge of the history, policies, and practices of public- and private-sector support for civic education programs in the United States over the past fifty years, nor a firm grounding in the facts regarding past and present funding of the Center or the probability of obtaining the level of support necessary from sources other than the Federal Government. To anyone aware of the history of support for civic education, it is clear that support for national and international programs in civic education of the magnitude of those implemented by the Center and described above is simply not available from sources other than the Federal Government. Federal funding is essential for the continuation of this program.

The Center has always sought and sometimes received support from other sources. In reference to the sources the ED report notes above, the Center did receive $1 million from the Pew Charitable Trusts in 1988 to develop and promote the implementation of CIVITAS: A Framework for Civic Education. In 1991, the Pew Charitable Trusts provided a grant of $400,000 to match funds the Center received from the Department of Education to develop the National Standards for Civics and Government. For several years the Joyce Mertz Gilmore Foundation awarded the Center $20,000 to partially offset the costs of an annual bilateral conference on civic education the Center conducted with the Federal Center for Political Education of Germany. For the past three years the Lincoln and Therese Filene Foundation has provided about $100,000 annually to support a summer institute for teachers. A similar level of support has, in some years, been provided for the same purpose by the National Endowment for the Humanities. The Center receives

$250,000 each year from the California State Department of Education to augment its Federal funding for the implementation of Project Citizen in California. Despite its efforts, the Center has never been able to secure sustained funding in more substantial amounts from such sources for its major programs.

The ED report claims that the Center receives income from "such vehicles as selling program-related curricular materials, trainings, and workshops." Support from ED enables the Center to provide approximately 450,000 free textbooks to schools each year. The Center grosses approximately $1 million each year from the sale of these texts, with the majority of these funds paying for printing, handling, and other overhead costs connected to the materials. The remainder of these funds is used to support and augment the programs supported with Federal funds. The Center does not receive funds for "trainings and workshops" which are, in fact, provided free to thousands of teachers each year under its federally supported programs.

Summary.—Although the expansion of the Center's efforts has at times been assisted through supplemental funding provided by States and foundations, the core of its efforts depends on the Federal dollars that the administration seeks to eliminate. Without these crucial funds, much of the Center's national and international networks and their many volunteers and programs in education for democracy will simply cease to exist. The Center seeks to continue to develop relationships with other agencies, nonprofit organizations, and funding sources to expand its operations and ultimately to institutionalize its efforts. However, if successful, the administration's attempt to discontinue funding would undermine the very possibility of institutionalizing the foremost civic education for democracy programs in the world by prematurely cutting the lifeline of the Center's networks and programs.

4. Chronological List of Research and Evaluation Studies Conducted by Internal and External Evaluators on Center Domestic and International Programs

1. *A Programmatic Evaluation of Civitas: An International Civic Education Exchange Program 2004–2005* (2006). Gary Marx, Center for Public Outreach. A report to the Center for Civic Education.

2. *We the People: The Citizen and the Constitution: 2005 National Finalists' Knowledge of and Support for American Democratic Institutions and Processes* (2006). Sharareh Frouzesh Bennett and Dr. Suzanne Soule, Center for Civic Education.

3. *Evaluation of We the People: Project Citizen Summer Institutes: How the Teachers Translated the Experience into Classroom Instruction* (2006). Jennifer Nairne, Center for Civic Education.

4. *Political Education Beyond National Borders: Teaching Democracy Abroad to Promote More Peaceful International Relations* (2005). Dr. Alden Craddock, Bowling Green State University. Paper presented at the 2005 German-American Conference—Responsible Citizenship, Education, and the Constitution.

5. *Project Citizen: Evaluation Report* (2005). RMC Research Corporation.

6. *An Analysis of the Depiction of Democratic Participation in American Civics Textbooks* (2005). Sharareh Frouzesh Bennett, Center for Civic Education. Paper presented at the 2005 German-American Conference—Responsible Citizenship, Education, and the Constitution.

7. *Changes in the Political Landscape and Their Implications for Civic Education* (2005). Dr. Margaret Branson, Center for Civic Education. Paper presented at the 2005 German-American Conference—Responsible Citizenship, Education, and the Constitution.

8. *Differences in Gender and Civic Education in Ukraine* (2005). Dr. Alden Craddock, Bowling Green State University. Paper presented at the European Consortium of Political Research General Conference.

9. *Advancing Peace and Stability through Active Citizenship: The Role of Civic Education* (2005). Dr. Margaret Branson, Center for Civic Education. Speech delivered at the Ninth Annual World Congress on Civic Education.

10. *Voting and Political Participation of We the People: The Citizen and the Constitution Alumni in the 2004 Presidential Election* (2005). Dr. Suzanne Soule, Center for Civic Education.

11. *Monitoring the Effectiveness of Youth Participation in Project Citizen: A Civitas-Russia Evaluation Project: Summary of Preliminary Findings* (2005). Dr. Charles White, Boston University.

12. *Civitas Latin America: A Civic Education Exchange Program Annual Evaluation Report, Year 2* (2005). West Ed. A report to the Center for Civic Education.

13. *A Programmatic Evaluation of Civitas: An International Civic Education Program 2003–2004* (2005). Gary Marx, Center for Public Outreach. A report to the Center for Civic Education.

14. *We the People: The Citizen and the Constitution Summer Institutes: How the Teachers Translated the Experience into Classroom Instruction* (2005). Jennifer Nairne, Center for Civic Education.
15. *American Identity, Citizenship, and Multiculturalism* (2005). Dr. Diana Owen, Georgetown University. Paper presented at the 2005 German-American Conference—Responsible Citizenship, Education, and the Constitution.
16. *Knowledge of and Support for American Democratic Institutions and Processes by Participating Students in the National Finals 2005* (2005). (Reports available from previous years 1999–2004). Dr. Suzanne Soule and Sharareh Frouzesh Bennett, Center for Civic Education.
17. *An Independent Evaluation of Civic Education Programs in Jordan, Egypt, and West Bank 2002–2003* (2004). Glaser Consulting Group.
18. *A Rising Tide in Indonesia: Attempting to Create a Cohort Committed to Democracy through Education* (2004). Dr. Suzanne Soule, Center for Civic Education.
19. *We the People Curriculum: Results of a Pilot Test* (2004). Dr. Ardice Hartry and Kristie Porter, MPR Associates, Inc.
20. *Civitas Latin America: A Civic Education Exchange Program Annual Evaluation Report, Year 1* (2004). WestEd.
21. *Evaluation Report on 2003 We the People: Project Citizen Summer Institutes* (2004). Sharareh Frouzesh Bennett, Center for Civic Education.
22. *Foundations of Democracy Program and Prevention of Aggressive Behavior of Children in Preschool Educational Institutions* (2003). Ivan Glasovac, Croatian evaluator.
23. *Learning to Live Together: An Evaluation of Civic-Link* (2003). Work Research Co-operative, independent evaluator.
24. *Creating a Cohort Committed to Democracy? Civic Education in Bosnia and Herzegovina* (2002). Dr. Suzanne Soule, Center for Civic Education.
25. *Voting and Political Participation of the We the People: The Citizen and the Constitution Alumni in the 2000 Presidential Election* (2001). Dr. Suzanne Soule, Center for Civic Education.
26. *Programmatic Evaluation of Civitas: An International Civic Education Exchange Program 2000–2001* (2001). Gary Marx, Independent Evaluator.
27. *Civic Education Assessment—Stage II. Civic Education Programming Since 1990—A Case Study Based Analysis* (2000). Dr. Franca Brilliant. Report for the U.S. Agency for International Development.
28. *Project Citizen and the Civic Development of Adolescent Students in Indiana, Latvia, and Lithuania* (2000). Drs. Thomas Vontz, Kay Metcalf, and John Patrick, Indiana University.
29. *Prevention of School Violence through Civic Educational Curricula: Year One of a National Demonstration Program* (2000). Dr. Kenneth Tolo, LBJ School of Public Affairs, University of Texas at Austin.
30. *Beyond Communism and War: The Effect of Civic Education on the Democratic Attitudes and Behavior of Bosnian Youth* (2000). Dr. Suzanne Soule, Center for Civic Education.
31. *Programmatic Evaluation of Civitas: An International Civic Education Exchange Program 1999–2000* (2000). Eva Stahl, independent evaluator.
32. *An Assessment of We the People . . . Project Citizen: Promoting Citizenship in Classrooms and Communities* (1998). Dr. Kenneth Tolo, LBJ School of Public Affairs, University of Texas at Austin.
33. *Bell Gardens Study on Fifth and Sixth Grade Participants in Center and Constitutional Rights Foundation Curricula* (1997). University of California, Los Angeles.
34. *Program Effectiveness Panel Validation of We the People* (1995). United States Department of Education National Diffusion Network.
35. *Civic Education and Political Attitudes: Examining the Effects on Political Tolerance of the We the People Curriculum* (1994). Dr. Richard Brody, Stanford University.
36. *Testing for Learning: How New Approaches to Evaluation Can Improve American Schools* (1992). Dr. Ruth Mitchell.
37. *An Evaluation of the Instructional Impact of the Elementary and Middle School Curricular Materials Developed for the National Bicentennial Competition on the Constitution and Bill of Rights* (1991). Educational Testing Service.
38. *A Comparison of the Impact of the We the People. . . Curricular Materials on High School Students Compared to University Students* (1991). Educational Testing Service.
39. *An Evaluation of the Instructional Effects of the Nationals Bicentennial Competition on the Constitution and Bill of Rights* (1988). Educational Testing Service.

PREPARED STATEMENT OF THE COLLEGE BOARD

ANCHORING MATHEMATICS AND SCIENCE EDUCATION REFORM IN AN EXPANDED ADVANCED PLACEMENT PROGRAM

Introduction

The College Board is a national not-for-profit association of more than 5,000 member schools, colleges and universities, with a challenging mission: To connect students to college success and opportunity. One of the College Board's most ambitious and important teaching and learning programs is the Advanced Placement Program (AP). As a set of 38 college-level courses taught in high school, AP has become the most influential general education program in the country, and it represents the highest standard of academic excellence in our Nation's schools. The AP Program is a collaborative effort between motivated students, dedicated teachers, expert college professors, and committed high schools, colleges, and universities. Ninety percent of the colleges and universities in the United States, as well as colleges and universities in 30 other countries, have an AP policy granting incoming students credit, placement or both on the basis of their AP Exam grades. Many of these institutions grant up to a full year of college credit (sophomore standing) to students who earn a sufficient number of qualifying AP grades. Since its inception in 1955, the AP Program has allowed millions of students to take college-level courses and exams, and to earn college credit or placement while still in high school.

President Bush's request for $90 million in new funding to train 70,000 new AP math, science, and world language teachers over the next five years will dramatically improve the quality of instruction in these areas. The ultimate outcome will include a substantial increase in the number of high school graduates who enter college with the desire and ability to succeed in science, technology, engineering, and mathematics (STEM) fields and compete in a global marketplace. Moreover, increased support for an expanded AP Program in these content areas will contribute to raising standards and achievement in all of our Nation's high schools. The AP Program benefits both the students who take AP courses and those who do not take AP by promoting higher standards and better teaching in all classes. As such, a significant investment in the expansion of AP math, science, and world language programs will have a profound effect on the overall quality of education in our Nation's schools.

AP is a 50-year-old, time-tested program with an existing infrastructure of tens of thousands of teachers and a network of hundreds of training sites across the country. Funds invested in this program will not need to be dedicated to creating a new system for teacher professional development, course development, or the administration and scoring of assessments. That system already exists as a result of our efforts over the past 50 years, and as a result of the involvement of thousands of schools, colleges and universities in the operation of the AP Program. Thus, new Federal dollars invested in AP can go directly into teacher training and student preparation and support.

The table on page four of this statement provides a summary of the total dollars that each State would receive through this initiative, and provides one model for the use of those funds that illustrates how many students and teachers could be served if the full $90 million request were supported.

THE AP PROGRAM

The principles and values of the AP Program can be stated quite simply:

—AP supports academic excellence. AP represents a commitment to high standards, hard work, and enriched academic experiences for students, teachers, and schools.

—AP is about equity. The AP Program should be open to all students, and we believe that every student should have access to AP courses and should be given the support he or she needs to succeed in these challenging courses.

—AP can drive school-wide academic reform. Schools that use AP as an anchor for setting high standards and raising expectations for all students see significant returns not just in terms of AP participation but in terms of increasing the overall quality and intensity of their academic programs.

Across the Nation, every State, and most school districts are exploring ways to raise standards and ensure that all students take challenging courses that prepare them for success in college and work. AP is recognized as a powerful tool for increasing academic rigor, improving teacher quality, and creating a culture of excellence in high schools. Students who take AP courses assume the intellectual responsibility of thinking for themselves, and they learn how to engage the world critically and analytically—both inside and outside of the classroom. This is an invaluable experi-

ence for students as they prepare for college or work upon graduation from high school. Moreover, schools in which AP is widely offered—and accessible to all students—experience the diffusion of higher standards throughout the entire school curriculum.

AP MATHEMATICS AND SCIENCE COURSES

Increasing rigorous math and science education in the United States will significantly boost our high school graduates' math and science proficiency—and also increase the number of students who enter college ready to succeed in science, technology, engineering, and mathematics (STEM) careers. And we urgently need to create those opportunities for our students. Today, only 32 percent of American undergraduates are earning degrees in science and engineering, compared to 66 percent of undergraduates in Japan, 59 percent in China, and 36 percent in Germany. In 2004, China graduated 600,000 engineers, India graduated 350,000, and the United States graduated 70,000.[1]

The AP Program is an important tool in this Nation's efforts to increase its economic competitiveness. AP math and science students are much more likely than other students to major in STEM disciplines than students whose first exposure to college-level math and science courses is in college. For example:

—Sixteen percent of students who take AP Chemistry go on to major in chemistry in college. By way of contrast, only 3–4 percent of students who take general chemistry instead of AP chemistry major in that field in college.

—More than 25 percent of students who take AP Calculus go on to major in a STEM field in college, and 40 percent of students who take AP Physics major in physics in college.

Furthermore, research indicates that AP math and science courses prepare American students to achieve a level of proficiency that exceeds that of students from all other nations. For example, in the most recent TIMSS assessments, U.S. Calculus students ranked number 15 (out of 16 countries) in the international advanced mathematics assessment. But AP Calculus students who scored a 3 or better on the AP Calculus Exam ranked first in the world. Even AP Calculus students who scored a 1 or 2 on the AP Calculus Exam—below "passing"—were ranked second in the world. AP Physics students, as compared to other U.S. physics students and physics students internationally, were also at the top of the ranking.

Most significantly, there are many, many more U.S. students who can succeed in AP math and science courses—if they are simply given the chance. This year in the United States, we anticipate that more than 100,000 students will earn a grade of 3 or above on the AP Calculus Exam—the grade typically required for college credit. But in a national analysis of the math proficiency of students enrolled in U.S. high schools during the 2005–2006 academic year, we can identify, by name and school, an additional 500,000 students who have the same academic background and likelihood of success in AP Calculus as the 100,000 students who currently are fortunate enough to have an AP Calculus course available. If we look at Biology, we see an even larger gap; we expect that about 74,000 students will earn exam grades of 3 or higher on the AP Biology Exam this year, whereas we know that at least 640,000 additional U.S. students have the academic skills that would enable them to succeed in AP Biology if they only had a course available to them and the encouragement to take on this challenge. There are literally hundreds of thousands of high school students in the United States who are prepared and ready to succeed in rigorous high school courses such as AP Calculus, AP Biology, AP Physics, and AP Chemistry. In many cases, the only thing preventing them from learning at this higher level is the lack of an AP teacher in their school or the lack of adequate encouragement and support to take the AP course.

The College Board believes AP has tremendous potential to drive reform in a powerful way in all of our Nation's schools. No single program can have as strong an impact on overall student and teacher quality as AP. AP is not for the elite, it is for the prepared. The Committee's support for expanded AP math, science, and world language courses and exams will prepare many more students for the opportunity to compete in a global environment and succeed in STEM fields in college and work. We respectfully urge that you fully fund the Administration's request for AP expansion.

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[1] Committee on Science, Engineering and Public Policy. Rising Above the Gathering Storm: Energizing and Employing America for a Brighter Economic Future. National Academies Press, 2006. This report notes that America appears to be on a "losing path" today with regard to our future competitiveness and standard of living.

State	Potential New 2007 AP funding Under President's Proposal	Total number of middle and high school teachers provided with Pre-AP or AP training	Number of students benefiting from teachers receiving Pre-AP training (20 students per 5 sections)	Number of students benefiting from teachers receiving AP training (25 students per AP teacher)
Alabama	$1,600,989	750	60,037	3,752
Alaska	453,123	212	16,992	1,062
Arizona	2,074,097	972	77,779	4,861
Arkansas	1,016,284	476	3,8111	2,382
California	12,527,993	5,872	469,800	29,362
Colorado	933,670	438	35,013	2,188
Connecticut	542,351	254	20,338	1,271
Delaware	453,123	212	,16992	1,062
District of Columbia	453,123	212	16,992	1,062
Florida	4,948,272	2,320	185,560	11,598
Georgia	2,823,013	1,323	105,863	6,616
Hawaii	453,123	212	16,992	1,062
Idaho	453,123	212	16,992	1,062
Illinois	3,228,779	1,513	121,079	7,567
Indiana	1,254,941	588	47,060	2941
Iowa	482,954	226	18,111	1,132
Kansas	537,051	252	20,139	1,259
Kentucky	1,335,985	626	50,099	3,131
Louisiana	2,012,675	943	75,475	4,717
Maine	453,123	212	16,992	1,062
Maryland	978,436	459	36,691	2,293
Massachusetts	1,093,966	513	41,024	2,564
Michigan	2,431,666	1,140	91,187	5,699
Minnesota	746,455	350	27,992	1,750
Mississippi	1,349,629	633	50,611	3,163
Missouri	1,418,338	665	53,188	3,324
Montana	453,123	212	16,992	1,062
Nebraska	453,123	212	16,992	1,062
Nevada	575,422	270	21,578	1,349
New Hampshire	453,123	212	16,992	1,062
New Jersey	1,500,749	703	56,278	3,517
New Mexico	827,151	388	31,018	1,939
New York	6,191,847	2,902	232,194	14,512
North Carolina	2,401,977	1,126	90,074	5,630
North Dakota	453,123	212	16,992	1,062
Ohio	2,504,484	1,174	93,918	5,870
Oklahoma	1,132,521	531	42,470	2,654
Oregon	902,459	423	33,842	2,115
Pennsylvania	2,659,829	1,247	99,744	6,234
Rhode Island	453,123	212	16,992	1,062
South Carolina	1,338,960	628	50,211	3,138
South Dakota	453,123	212	16,992	1062
Tennessee	1,661,104	779	62,291	3,893
Texas	8,742,609	4,098	327,848	20,490
Utah	479,572	225	17,984	1,124
Vermont	453,123	212	16,992	1,062
Virginia	1,443,618	677	54,136	3,383
Washington	1,340,908	629	50,284	3,143
West Virginia	615,683	289	23,088	1,443
Wisconsin	934,028	438	35,026	2,189
Wyoming	453,123	212	16,992	1,062
American Samoa	453,123	212	16,992	1,062
Guam	453,123	212	16,992	1,062
Northern Mariana Islands	453,123	212	16,992	1,062
Puerto Rico	3,877,930	1,818	145,422	9,089
Virgin Islands	453,123	212	16,992	1,062
Freely Associated States	.....	.....	.....	.....
Indian set-aside	.....	.....	.....	.....
Other (non-State allocations)	455,400	213	1,7078	1,067
Total	91,080,000	42,694	3,415,500	213,469

PREPARED STATEMENT OF THE COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION (CSAVR)

This testimony is submitted on behalf of the Council of State Administrators of Vocational Rehabilitation (CSAVR). The CSAVR is composed of the chief administrators of the State Vocational Rehabilitation (VR) Agencies serving individuals with physical and/or mental disabilities in the United States, the District of Columbia and the Territories. These agencies constitute the State partners in the State-Federal Program of Rehabilitation Services provided under Title 1 the Rehabilitation Act of 1973, as amended. State VR agencies provide individualized services and supports to eligible individuals with significant disabilities that are required for them to go to work. These services may include, but are not limited to, counseling and guidance, job training, higher education, physical and mental restoration services, and assistive technology. Nearly 1 million individuals with disabilities are served annually. In fiscal year 2005, these agencies placed 206,695 individuals with disabilities into competitive employment.

The CSAVR, founded in 1940 to furnish input into the State-Federal Rehabilitation Program, provides a forum for State administrators to study, deliberate, and act upon matters affecting the rehabilitation and employment of individuals with disabilities. The Council serves as a resource for the formulation and expression of the collective points of view of State rehabilitation agencies on all issues affecting the provision of quality employment and rehabilitation services to persons with significant disabilities.

CSAVR'S RECOMMENDATION FOR THE FISCAL YEAR 2007 APPROPRIATION FOR THE PUBLIC VOCATIONAL REHABILITATION PROGRAM

For fiscal year 2007, CSAVR recommends an increase in the Vocational Rehabilitation (VR) appropriation of $258 million above the President's budget request for fiscal year 2007. The President's budget proposes a 4.3 percent increase in funding for the Public VR program, which is the mandated CPI increase, called for in law. However, the President's budget request also eliminates funding for several smaller programs, Supported Employment (SE), Projects with Industry (PWI), and Migrant and Seasonal Farm Workers (MSFW), with a total loss of funding of 51.7 million. With the majority of State VR Agencies operating under an Order of Selection, a system of prioritization whereby individuals with the most significant disabilities are served first, it is unlikely that the State VR Agencies would be able to continue to provide services, under Title 1 of the Rehabilitation Act, to all of the individuals previously served under the programs that lost their funding.

In addition to the proposed elimination of the SE, PWI, MSFW, and Recreation programs, which CSAVR does not support, HR 27, the House bill to reauthorize the Workforce Investment Act (WIA), and S 1021, the Senate bill to reauthorize the WIA, expands the requirements for VR to provide transition services to students with disabilities. Based on the significant internal and external challenges facing the Public VR Program, (i.e., staffing shortages, State budget shortfalls, increased numbers of consumers seeking services, and increased service costs and expectations, the CSAVR believes that an increased appropriation of 258 million above the President's budget request for VR, for fiscal year 2007, is an appropriate recommendation.

The CSAVR is requesting a $206 million increase specifically for the purposes of implementing the new transition requirements in the Rehabilitation Act. The most recent data on transition students, published in 2003 in the Individuals with Disabilities Education Act (IDEA) 25 Annual Report to Congress, indicates that there were 2,791,886 students between the ages of 12–17 and 283,265 between the ages of 18–21. A small sample survey of State VR Agencies revealed that the average annual cost to serve a transition student is $2062.00. The CSAVR will have the capacity to serve 100,000 new transition students in fiscal year 2007, with a funding increase of $206 million.

In addition, CSAVR is requesting that you restore the $51.7 million to the MSFW, the SE and the PWI programs, whose budgets were eliminated in the President's budget request for fiscal year 2007.

These three programs are vital to VR consumers and desperately needed to assure that vital support services, necessary for successful employment of certain populations, are maintained.

THE PUBLIC VOCATIONAL REHABILITATION PROGRAM

The Public VR Program is one of the most cost-effective programs ever created by Congress. It enables hundreds of thousands of individuals with disabilities to go

to work each year and become tax-paying citizens. In fiscal year 2005, the VR Program assisted 984,315 individuals with disabilities who wanted to work, by providing them with the job skills, training and support services they needed to become employed. Of those served, 206,695 entered into competitive employment. Funding for the VR Program requires a State match of 21.3 percent, and creates a State-Federal partnership that has worked effectively for more than 86 years, and has assisted approximately 16 million individuals with disabilities to engage in employment and become tax-paying citizens.

The Rehabilitation Act mandates that the annual Federal appropriation for the VR Program grow at a rate at least equal to the change in the Consumer Price Index (CPI) over the previous fiscal year. While the mandate was intended to create a floor for the VR appropriation, Congress has not appropriated funds above the mandated CPI increase since 1999. This is particularly problematic because the formula used to distribute these funds, which is based on a State's per capita income and population, results in significant variations in the increases in individual State's allotments. When the increase is limited to the CPI increase and the formula is applied, not all States receive increases that are equal to the annual rate of inflation. In fiscal year 2006, 30 States did not receive the required CPI increase in their State allotment.

CHALLENGES FACING THE PUBLIC VR PROGRAM

Over the last several years, the Public VR Program has faced a number of external challenges that have been compounded by the minimal increases in Federal funding.

SPECIAL EDUCATION

Between 1990 and 2004, the Federal appropriation for special education increased by approximately 333 percent. During the same time period, the Federal appropriation for the Public VR Program increased by only 22 percent. As a result of these very significant increases in special education funding, an ever-increasing number of special education students are exiting the education system and seeking adult services, including Vocational Rehabilitation, in order to participate in post secondary education, job training, and/or to go to work.

IMPACT OF THE WORKFORCE INVESTMENT ACT OF 1998 (WIA)

The Public VR Program is a mandatory partner in the WIA and, as such, is required to contribute significant resources to support the infrastructure and other costs associated with the operation of the One-Stop Centers. While VR's involvement in State Workforce Investment Systems is critically important, WIA has placed yet another financial burden on an already strained program, further reducing the percentage of VR funds that are available to provide services and supports to eligible individuals with disabilities. In addition, the House bill to reauthorize the WIA, H.R. 27, proposes to take significant resources from the Public VR Program far beyond the resources contributed to the One-Stop Centers under current law. The Senate bill, S. 1021, also requires resources from VR to fund the infrastructure costs and other common costs associated with the operation of One-Stop Centers; however, the CSAVR is very grateful for the graduated CAP on infrastructure funding for VR in S. 1021.

—A 2002 Longitudinal Study of the Public VR Program provided evidenced based research that the VR Program is effective in putting people with disabilities to work in good jobs with opportunities for advancement.

—A fiscal year 2006 Program Assessment Rating Tool (PART) Review, conducted by the Office of Management and Budget (OMB) to rate program performance, rated the VR Program favorably, and in general, successful in meeting its program goal.

—A report by the Social Security Administration, released annually, provides detailed information on the funds disbursed to State VR Agencies, based on their successfully serving beneficiaries on Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). In fiscal year 2004 SSA projected a 470.3 million savings to the Trust Fund by the VR Program, and established that every $1.00 that SSA spends on VR results in a $6.00 savings.

In this era of significant Federal and State budget deficits, and an increase in the unemployment rate for individuals with disabilities, we urge you to consider an increase in funding for the Public VR Program, through which you can be assured to have positive outcomes, based on the three factors mentioned above.

Our Nation's ability to be competitive in a global economy depends on the quality of our workforce. According to information provided by the Department of Labor,

Employment & Training Administration, during the fiscal year 2006 Budget Briefing, the American workforce will be vastly different than it is today, as the 21st century unfolds. The fastest growing jobs of the future will need to be filled by "knowledge workers," who have specialized skills and training. Ninety percent of the fastest growing jobs in the United States (U.S.) require some level of post-secondary education and training. Yet, the U.S. Census Bureau reports that in the United States, just 28 percent of those 25 and older in 2004 had a bachelor's degree. Integrating all available workers into the workforce, including workers with significant disabilities, will be required for employers to meet the demands of the 21st century economy. Significant numbers of large and small employers have acknowledged that hiring individuals with disabilities makes good business sense. It provides them with dependable workers and access to a market of individuals with spending power, which has historically been untapped. These same employers also have longstanding, positive relationships with VR, to whom they look to provide them with qualified workers with disabilities. Integrating all available workers into the workforce, including workers with disabilities, will require significant resources.

Recently, the CSAVR developed a National VR/Business Network for the purposes of increasing significantly, the number and quality of employment opportunities for VR's consumer. This National Network, spearheaded by CSAVR's Director of Business Relations, has already expanded the number of employment opportunities available to VR's consumers in a significant number of States, and is continuing to grow. VR's positive relationships with employers, who rely heavily on the Public VR Program to meet their hiring needs, further emphasizes and documents the need for additional resources for VR.

The Public VR Program, 86 years of history, 16 million individuals served, and a demonstrated return on investment. With additional resources, the Public VR Program can do more of what it does best—provide the resources for individuals with disabilities to go to work and live the American Dream.

The CSAVR thanks the Chairman and Members of the Senate Appropriations subcommittee for the opportunity to submit written testimony on behalf of the Public VR Program.

PREPARED STATEMENT OF GALLAUDET UNIVERSITY

Mr. Chairman and members of the committee: I would like to express my appreciation to you and to Congress for the generous support that we received in fiscal year 2006 to continue maintaining and enhancing academic programs and salaries at Gallaudet University. I am especially grateful that Congress continues to support us during these challenging times, and I am testifying in support of our appropriation request for fiscal year 2007. As I prepare to retire as President at the end of this calendar year, I would particularly like to express my appreciation for the support that Congress has provided to Gallaudet during the 18 years of my administration and of majority control of the Board of Trustees by deaf individuals. One of my proudest accomplishments is the increase in the percentages of our employees who are deaf or members of minority groups. These percentages now stand at 41 percent and 38 percent respectively.

Consistent with our legal purpose, as stated in the Education of the Deaf Act (EDA), we have greatly expanded programs at the doctoral level. When I became President, we had only one doctoral level program in administration and supervision—we now have additional doctoral programs in audiology, clinical psychology, education, and linguistics. At the undergraduate level we have focused on programs, such as tutoring and first year seminars, designed for long term enhancement of our persistence and graduation rates, and we have initiated a much needed bachelor's level interpreter training program. At the Clerc Center, following guidance from Congress during the 1992 reauthorization of the EDA, we have refocused our demonstration and outreach activities at the pre-college level on high priority student populations throughout the United States.

During my presidency, Gallaudet responded to the Government Performance and Results Act (GPRA). In 2005, we had 31 ambitious goals published under GPRA, with 17 of those fully accomplished in that year. These goals reflect the wide array of programs and services that Gallaudet provides as required by legislative mandate and performance expectations as agreed to with the U.S. Department of Education. During 2005, Office of Management and Budget (OMB) conducted a Program Assessment Rating Tool (PART) of Gallaudet, and, based on a limited and narrow set of GPRA indicators, it gave Gallaudet an "ineffective" rating. I protested the rating in part because of the assessment's limited scope and also because we were not involved in the assessment. I am pleased to inform you that OMB has agreed to con-

duct a reassessment of Gallaudet this year, and I will insist on a broader set of indicators that truly represent Gallaudet's complex mission.

When I became President in 1988, every building on the Kendall Green campus had been constructed with virtually 100 percent Federal funding. Since I became President, every major construction or renovation project we have undertaken has been supported either by cost-sharing with the Federal Government or by private fundraising alone. For example, the buildings constructed here most recently, the Kellogg Conference Hotel at Gallaudet University and the Student Academic Center, were constructed without any additional Federal appropriations. We are currently well on the way to raising the funds needed for a facility to house our language and communication programs, including a $5 million leadership gift from the Sorenson family of Utah.

When I became President, the Gallaudet endowment was valued at $10 million. Partly with the assistance of the Federal Endowment Program created by the 1986 passage of the Education of the Deaf Act, our endowment now stands at $165 million and generates more than $4 million in annual income to support programs and scholarships.

When I became President in 1988, total staffing at Gallaudet stood at about 1,450 employees. Following a comprehensive staffing reduction program, it now stands at just over 1,100, a reduction of more than 20 percent. This reduction provided much needed budget flexibility during a time when Congress was seeking to reduce the Federal budget deficit. During my tenure, we have also decreased the proportion of our operating budget that is supported by Federal appropriations by about 10 percentage points. This reduction was made possible in part by a long term plan to increase tuition charges to Gallaudet students, following an agreement between the University and the Department of Education. For many years, we increased tuition at 7 percent annually, more than twice the rate of inflation. Following expressions of concern by members of Congress and by a consulting group we retained to study our tuition policy, we reduced these increases to 3 percent annually starting in fiscal year 2006. I believe that we have been very responsible in our requests for Federal support and that we have done everything we could to seek additional sources of funding during a time when Congress has faced funding limitations.

Because of Congress's ongoing support of Gallaudet in fiscal year 2006, we have been able to maintain a competitive pay structure for our employees while retaining the flexibility to meet the needs of a changing student body. Given the unique student population we serve and the communication skills our employees are expected to possess, retaining skilled employees is critical to our mission. Gallaudet employees received general pay increases of 2 percent in fiscal year 2003, 3 percent in fiscal year 2004, 2 percent in fiscal year 2005, and 2 percent again in fiscal year 2006, increases that are below what Federal employees in the region received during the same timeframe, but in line with increases in the Consumer Price Index (CPI). During the most recent 12 month period, the CPI–U increased by 4 percent. It will be important for Gallaudet to ensure that our employees receive at least a 3 percent general pay increase in fiscal year 2007, commensurate with current increases in inflation. We are also requesting support for inflationary increases in non-salary areas, especially in the cost of utilities and benefits. In this regard, I need to point out that our benefits charges during the past several years have increased by more than 2 percent of base salaries, and we have had to fund those increases as part of our total payroll package.

The administration budget for fiscal year 2007 includes $106.998 million for Gallaudet, the same as our current fiscal year 2006 appropriation. I have carefully analyzed our fiscal year 2006 funding needs and have determined that in order to award a 3 percent salary increase to our faculty and staff, and to meet other inflation-driven increases, we need an increase of about $5 million, 4.7 percent above our current appropriation. All of our planning is now guided by a comprehensive strategic plan driven by eight goals, arrived at in consultations involving our Board, and our faculty and staff, relating to student academic achievement within the liberal arts tradition, excellence in research and other programs, diversity among students and employees, leadership in the deaf community, and maintenance of a strong resource base.

FUNDING REQUEST FOR FISCAL YEAR 2007

In our budget request to the Department of Education for fiscal year 2007, we addressed the need for inflationary increases as well as support for program development. Given the funding issues currently facing Congress, I am requesting support at this time for only our most pressing inflationary needs. Funding our need to cover inflationary costs will provide us some budget stability, but we will continue

to face the need for development and enhancement of our programs. Our strategy will be to seek alternative sources of funding for some of these program priorities and to defer others. We will continue to seek support for program growth from both Federal and private sources in the future.

Salaries.—I am requesting support for a 3 percent increase in salaries, approximately $2.6 million.

Benefits.—I am requesting support for increases in benefits costs that have created the need for increasing charges to our operating units by 2 percent of base salaries, approximately $1.4 million.

Utilities.—The total cost for utilities at Gallaudet rose by $1.8 million, or 50 percent, between fiscal year 2002 and 2005, and I expect these costs to continue rising steeply in fiscal year 2006. I am seeking $1 million to partially offset these increases.

My total request for fiscal year 2007 is, thus, $112 million.

In summary, I appreciate the challenges that Congress faces in making appropriations decisions for fiscal year 2007, but I believe experience has shown that Gallaudet provides an outstanding return on Federal dollars that are invested here, in terms of the educated and productive deaf community that the Nation enjoys as a result.

PREPARED STATEMENT OF THE HEALTH PROFESSIONS AND NURSING EDUCATION COALITION

The members of the Health Professions and Nursing Education Coalition (HPNEC) are pleased to submit this statement for the record in support of the health professions education programs authorized under Titles VII and VIII of the Public Health Service Act.

HPNEC is an informal alliance of over 50 organizations representing a variety of schools, programs, health professionals, and others dedicated to ensuring that Title VII and VIII programs continue to help educate the Nation's health care and public health personnel. HPNEC members are thankful for the support the subcommittee has provided to the programs, which are essential to building a well-educated, diverse health care workforce.

The Title VII and VIII health professions and nursing programs are essential components of Americans' health care safety net, bringing health care services to our underserved communities. These programs support the training and education of health care providers with the aim of enhancing the supply, diversity, and distribution of the workforce, filling the gaps in the health professions' supply not met by traditional market forces. The Title VII and VIII health professions programs are the only Federal programs designed to train providers in interdisciplinary settings to meet the needs of special and underserved populations, as well as increase minority representation in the health care workforce.

The final fiscal year 2006 Labor-HHS-Education Appropriations bill cut Title VII & VIII programs by 34.5 percent, including a 51.5 percent cut to Title VII programs. Moreover, the President's fiscal year 2007 budget proposes an additional 93.1 percent cut to Title VII and a 45.8 percent cut overall to both Title VII and VIII.

HPNEC members recommend that the Title VII and VIII programs receive an appropriation of at least $550 million for fiscal year 2007. This recommendation would ensure the programs have sufficient funds to continue fulfilling their mission of educating and training a health care workforce that meets the public's health care needs, restoring some of the unprecedented cuts imposed on the programs in fiscal year 2006.

As described in an April 5 letter to the subcommittee, led by Senators Pat Roberts and Jack Reed, and signed by 56 of your colleagues (letter attached), restoring funding to Title VII health professions programs is vital to reversing health professions shortages in the Nation's neediest communities. An April 3 letter led by Senators Susan Collins and Barbara Mikulski was signed by 54 Senators in support of adequate funding for Title VIII nursing programs as well (letter attached).

The enacted and proposed cuts to the programs will:

Exacerbate existing provider shortages in rural, medically underserved, and federally designated health professions shortage areas

—With Title VII funding, the Department of Family Medicine at Pennsylvania State University increased the number of students entering primary care to 50 percent of all graduates. Through rural rotations and required primary care clerkships, Penn State placed 30 percent of graduates into medically underserved areas over the last three years. With cutbacks in Title VII funding, they

will lose their ability to continue producing physicians for underserved and rural areas.

—According to the University of Nebraska Medical Center, eliminating Title VII funding will cut off access to psychologists for many families in rural areas. Over the last four years, the Munroe Meyer Institute Department of Psychology has served children and families from over 140 Nebraska cities and towns (3,500 patients each year), and has placed Pediatric Psychologists in five rural primary care practices. The rural programs will be in severe financial crisis as a result of cuts, which would further reduce Nebraska's already severely limited mental health services to its rural citizens.

Impede recruitment of underrepresented minorities and students of disadvantaged backgrounds into the health professions and intensify health disparities among minority and underserved citizens

—The Saint Louis University School of Medicine operates a Health Careers Opportunity Program (HCOP). The negative impact of the elimination of Federal funding on the development of pipeline programming will be significant, as over 2,300 K–12 students annually participate in one or more pipeline programs. A correlative impact will be in the area of minority/disadvantaged recruitment, as pipeline programs heighten awareness of opportunities for medical and premedical training (i.e., research opportunities) at Saint Louis University. Elimination of Federal dollars will severely limit the ability of Saint Louis University to continue to impact young people at an early age to begin thinking about medicine. A reduction in minority enrollment is certain to occur at a time when enrollment diversity is having critical implications on institutional and faculty development, as well as on cultural competency initiatives.

—The University of Illinois' College of Medicine has received Federal funding for its HCOP program for over 25 years and has graduated over 1400 health professionals. With a loss of funds, the school expects that the breadth of its recruitment activities will be curtailed, resulting in fewer contacts with underrepresented students, truncating the opportunities for exposing students to medicine as a career choice, to financial aid information, to curriculum preparedness, etc. These programmatic impacts will shape the medical profession as a whole, as there will be fewer underrepresented minorities who are recruited, retained, and who graduate to become physicians; fewer underrepresented minorities who are able to assist in bridging the dearth of medical care in underserved areas; fewer underrepresented minorities who are able to continue eliminating health disparities and contributing to health policy; and fewer underrepresented minorities who are culturally competent to appropriately provide health care services to the Nation's historically underserved populations.

Negatively impact vulnerable populations such as the elderly

—Over four years, the South Carolina Geriatric Education Center (GEC) has trained over 6,000 physicians. The enacted cuts to Title VII programs eliminate funding for geriatrics programs, including those at the University of South Carolina School of Medicine and the Medical University of South Carolina. As one of the top five States in rate of growth for older individuals, the direct impact on educating physicians and other health professionals on the special needs of aging adults will reverberate throughout South Carolina. On a national scale, the cuts will affect 50 GECs throughout the country which train over 50,000 health care professionals representing 35 disciplines annually. These centers log 8.6 million patient encounters each year, and over two-thirds of GECs serve rural areas and underserved populations. The effect of this lost funding is devastating to both academic institutions and older individuals who will not receive care from health professionals equipped to address their unique needs.

Undermine efforts to encourage health professions students to enter primary care

—The University of California, San Diego School of Medicine reports that 71 percent of UCSD Hispanic Center of Excellence (HCOE) alumni completed or are completing primary care residencies, compared to only 57 percent of the UCSD alumni, graduating in 2002–2004, who have completed or are completing primary care residencies.

A November 2002 report by the Advisory Committee on Training in Primary Care Medicine and Dentistry emphasizes the essential role of the Title VII programs in enhancing public health training for the primary care health workforce. In its recommendations, the committee notes that in 1998, 42 to 56 percent of graduates from the Title VII-supported primary care programs entered practice in underserved areas, compared to a mean of 10 percent of health professions graduates overall. Data from 1998 also indicate that 35 to 50 percent of graduates of these programs

represented minority or disadvantaged groups, compared to 10 percent minority representation overall.

Community health centers (CHCs) also benefit from Title VII and VIII programs. A March 2006 study published in the Journal of the American Medical Association found that community health centers report high percentages of provider vacancies, including an insufficient supply of dentists, pharmacists, pediatricians, family physicians, and registered nurses; these shortages are especially pronounced among CHCs in rural areas. Because Title VII programs have a successful record of training providers who serve underserved areas, the study recommends increased support for the programs as its primary means of alleviating the shortages. Further, the publication serves as an important reminder that the success of CHCs is highly dependent upon a well-trained clinical staff to provide care.

During their 40-year existence, the Title VII and VIII programs have created a network of initiatives across the country that supports the training of many disciplines of health providers. These are the only Federal programs designed to create infrastructures at our schools and in our communities that facilitate customized training designed to bring the latest emerging national priorities to the populations at large and meet the health care needs of special, underserved populations.

HPNEC members urge the subcommittee to consider the vital need for these health professions education programs as demonstrated by the passage of the Health Professions Education Partnerships Act of 1998 (Public Law 105–392), which reauthorized these programs. The reauthorization provided additional flexibility in the administration of these programs and consolidated them into seven general categories: Minority and Disadvantaged Health Professions Training; Primary Care Training; Interdisciplinary, Community-Based Linkages; Health Professions Workforce and Analysis; Public Health Workforce Development; Nursing Workforce Development; and Student Financial Assistance.

—The purpose of the Minority and Disadvantaged Health Professionals Training programs is to improve health care access in underserved areas and the representation of minority and disadvantaged health care providers in the health professions. Minority Centers of Excellence support programs that seek to increase the number of minority health professionals through increased research on minority health issues, establishment of an educational pipeline, and the provision of clinical opportunities in community-based health facilities. The Health Career Opportunity Program seeks to improve the development of a competitive applicant pool through partnerships with local educational and community organizations. The Faculty Loan Repayment and Faculty Fellowship programs provide incentives for schools to recruit underrepresented minority faculty. The Scholarships for Disadvantaged Students (SDS) make funds available to eligible students from disadvantaged backgrounds who are enrolled as full-time health professions students. Nursing students receive 16 percent of the funds appropriated for SDS.

—The Primary Care Training category, including General Pediatrics, General Internal Medicine, Family Medicine, General Dentistry, Pediatric Dentistry, and Physician Assistants, provides for the education and training of primary care physicians, dentists, and physician assistants to improve access and quality of health care in underserved areas. As noted in the November 2002 Advisory Committee report, two-thirds of all Americans interact with a primary care provider every year, and approximately one-half of primary care providers trained through these programs go on to work in underserved areas, compared to 10 percent of those not trained through these programs. The General Pediatrics and General Internal Medicine programs provide critical funding for primary care training in community-based settings and have been successful in directing more primary care physicians to work in underserved areas. They support a range of initiatives, including medical student training, residency training, faculty development and the development of academic administrative units. Title VII is the only Federal program that provides funding for family medicine residency training, academic departments, predoctoral programs, and faculty development. The General Dentistry and Pediatric Dentistry programs provide grants to dental schools and hospitals to create or expand primary care dental residency training programs. Recognizing that all primary care is not only provided by physicians, the primary care cluster also provides grants for physician assistant programs to encourage and prepare students for primary care practice in rural and urban Health Professional Shortage Areas. Additionally, these programs enhance the efforts of osteopathic medical schools to continue to emphasize primary care medicine, health promotion, and disease prevention, and the practice of ambulatory medicine in community-based settings.

—Because much of the Nation's health care is delivered in areas far removed from health professions schools, the Interdisciplinary, Community-Based Linkages cluster provides support for community-based training of various health professionals. These programs are designed to provide greater flexibility in training and to encourage collaboration between two or more disciplines. These training programs also serve to encourage health professionals to return to such settings after completing their training. The Area Health Education Centers (AHECs) provide clinical training opportunities to health professions and nursing students in rural and other underserved communities by extending the resources of academic health centers to these areas. AHECs, which have substantial State and local matching funds, form networks of health-related institutions to provide education services to students, faculty and practitioners. Health Education and Training Centers (HETCs) were created to improve the supply of health professionals along the U.S.-Mexico border. They incorporate a strong emphasis on wellness through public health education activities for disadvantaged populations. Given America's burgeoning aging population, there is a need for specialized training in the diagnosis, treatment, and prevention of disease and other health concerns of the elderly. Geriatric Health Professions programs support geriatric faculty fellowships, the Geriatric Academic Career Award, and Geriatric Education Centers, which are all designed to bolster the number and quality of health care providers caring for our older generations. The Quentin N. Burdick Program for Rural Health Interdisciplinary Training places an emphasis on long-term collaboration between academic institutions, rural health care agencies and providers to improve the recruitment and retention of health professionals in rural areas. The Allied Health Project Grants program represents the only Federal effort aimed at supporting new and innovative education programs designed to reduce shortages of allied health professionals and create opportunities in medically underserved and minority areas. Health professions schools use the funding to help establish or expand allied health training programs. The need to address the critical shortage of certain allied health professionals has been repeatedly acknowledged. For example, this shortage has received special attention given past bioterrorism events and efforts to prepare for possible future attacks. The allied health project grants funding enables the training of much needed allied health professionals, including those experiencing significant shortages. The Graduate Psychology Education Program provides grants to American Psychological Association accredited doctoral, internship and postdoctoral programs in support of interdisciplinary training of psychology students with other health professionals for the provision of mental and behavioral health services to underserved populations (i.e., older adults, children, chronically ill, and victims of abuse and trauma, including returning military personnel and their families), especially in rural and urban communities. Since its inception in 2002, the GPE Program has supported 52 grants in 27 States.

—The Health Professions Workforce and Analysis program provides grants to institutions to collect and analyze data on the health professions workforce to advise future decision-making on the direction of health professions and nursing programs. The Health Professions Research and Health Professions Data programs have developed a number of valuable, policy-relevant studies on the distribution and training of health professionals, including the soon-to-be-released Eighth National Sample Survey of Registered Nurses (NSSRN), the Nation's most extensive and comprehensive source of statistics on registered nurses.

—The Public Health Workforce Development programs are designed to increase the number of individuals trained in public health, to identify the causes of health problems, and respond to such issues as managed care, new disease strains, food supply, and bioterrorism. The Public Health Traineeships and Public Health Training Centers seek to alleviate the critical shortage of public health professionals by providing up-to-date training for current and future public health workers, particularly in underserved areas. Preventive Medicine Residencies, which receive minimal funding through Medicare GME, provide training in the only medical specialty that teaches both clinical and population medicine to improve community health. Dental Public Health Residency programs are vital to the Nation's dental public health infrastructure. The Health Administration Traineeships and Special Projects grants are the only Federal funding provided to train the managers of our health care system, with a special emphasis on those who serve in underserved areas.

—The Nursing Workforce Development programs provide training for entry-level and advanced degree nurses to improve the access to, and quality of, health care in underserved areas. Health care entities across the Nation are experi-

encing a crisis in nurse staffing, caused in part by an aging workforce, an insufficient number of young people entering the profession, and a shortage of nurse faculty. At the same time, the need for nursing services is expected to increase significantly over the next 20 years, with the demand for licensed, registered nurses growing by over 29 percent within the next nine years alone. Congress responded to this dire national need by passing the Nurse Reinvestment Act (Public Law 107–205) which aims to attract more people into the nursing profession, increase the capacity for nurse education, and encourage practicing nurses to remain in the profession. The Advanced Education Nursing program awards grants to train a variety of advanced practice nurses, including nurse practitioners, certified nurse-midwives, nurse anesthetists, public health nurses, and nurse administrators. Workforce Diversity grants support opportunities for nursing education for disadvantaged students through scholarships, stipends, and retention activities. Nurse Education, Practice, and Retention grants are awarded to help schools of nursing, academic health centers, nurse managed health centers, State, and local governments, and other health care facilities to develop programs that provide nursing education, promote best practices, and enhance nurse retention. The Loan Repayment and Scholarship Program repays up to 85 percent of nursing student loans and offers individuals who are enrolled or accepted for enrollment as a full-time or part-time nursing student the opportunity to apply for scholarship funds. In return these students are required to work for at least two years of practice in a designated nursing shortage area. The Comprehensive Geriatric Education grants assist in training individuals to provide geriatric care for the elderly. The Nurse Faculty Loan program provides a student loan fund administered by schools of nursing to increase the number of qualified nurse faculty. The Title VIII nursing programs also support the National Advisory Council on Nurse Education and Practice, which is charged with advising the Secretary of Health and Human Services and Congress on nursing workforce, education, and practice improvement issues.

—The loan programs in the Student Financial Assistance support needy and disadvantaged medical and nursing school students in covering the costs of their education. The Nursing Student Loan (NSL) program provides loans to undergraduate and graduate nursing students with a preference for those with the greatest financial need. The Primary Care Loan (PCL) program provides loans covering the cost of attendance in return for dedicated service in primary care. The Health Professional Student Loan (HPSL) program provides loans covering the cost of attendance for financially needy health professions students based on institutional determination. The NSL, PCL, and HPSL programs are funded out of each institution's revolving fund and do not receive Federal appropriations. The Loans for Disadvantaged Students (LDS) program provides grants to health professions institutions to make loans to health professions students from disadvantaged backgrounds.

HPNEC members respectfully urge support for funding of at least $550 million for the Title VII and VIII programs, an investment essential not only to the development and training of tomorrow's health care professions but also to our Nation's efforts to provide needed health care services to underserved and minority communities. We greatly appreciate the support of the subcommittee and look forward to working with members of Congress to achieve these goals in fiscal year 2007 and into the future.

PREPARED STATEMENT OF THE INSTITUTE FOR STUDENT ACHIEVEMENT

Mr. Chairman and Members of the subcommittee, thank you for the opportunity to submit testimony to the hearing record regarding the Institute for Student Achievement (ISA), a national not for profit educational organization.

INTRODUCTION TO THE INSTITUTE FOR STUDENT ACHIEVEMENT

The Institute for Student Achievement's mission is "to improve the quality of education for youth at risk so that they can succeed in our society." ISA has had a solid 15 year history of promoting high achievement for underserved students, first through its legacy direct service programs, COMET (for middle school) and STAR (for high school), and now through its school reform model. ISA launched its high school reform model in September 2001, with four pilot sites, three in New York City and one in Fairfax County, Virginia. As you know, funds to expand the work of ISA have been included in recent appropriations cycles, and we appreciate the support of the subcommittee. As a result we have created 31 small schools and

learning communities serving over 8,000 students in New York State, Virginia (in partnership with Fairfax County Schools), Atlanta, Georgia and Union City, New Jersey.

ISA partners with school districts to create new small schools or to transform large existing high schools into clusters of autonomous small schools or semi-autonomous small learning communities. The ISA high school reform model targets underserved, underperforming young people, including students from low-income families, students of color, recent immigrants and English Language Learners. ISA helps schools to develop small learning communities with the seven school design principles that have succeeded in preparing all high school students, including those who are disadvantaged and underperforming, to achieve, graduate, and go on to college.

Briefly described, the 7 ISA Principles are:

A College Preparatory Instructional Program promoting rigorous intellectual development, strong literacy and numeracy skills, critical thinking, habits of mind and work, and practical knowledge of the college application process.

A Dedicated Team of Teachers and a Counselor who collaborate to ensure that students develop and achieve academically and socially.

Continuous Professional Development that strengthens the capacities of teachers, counselors and school leaders to effectively provide a college preparatory program through rich professional growth experiences; regularly scheduled team meetings; classroom interventions for teachers; and customized professional development on topics ranging from inquiry in science to conflict resolution.

Distributed Counseling™ an approach in which faculty get to know all students well, as both learners and people, and integrate counseling into the education program so that students graduate ready for college. The counselor provides ongoing guidance to the teacher/advisors and direct services to students and their families.

An Extended School Day and School Year provide extra time for students to develop skills, complete assignments, engage in test preparation, participate in community service projects and internships, and have opportunities for talent development and enrichment.

Parent Involvement is integrated into school operations. The school program is designed to allow—and encourage—parents to be full partners in realizing educational excellence for their children.

Continuous Organizational Improvement focuses on optimizing student learning. ISA and its higher education partner, the National Center for Restructuring Education, Schools and Teaching (NCREST) of Teacher's College, Columbia University, work with the small schools and small learning communities to assess and evaluate in order to inform instruction and enhance program development.

In each ISA small learning community or small school, a team of at least four core subject teachers and a guidance counselor is dedicated to a group of 100–125 students, staying with the students over multiple years. Each ISA small school or small learning community selects an ISA coach, who is experienced in the development of small or restructuring schools, brings substantive knowledge of one or more core content areas, and has considerable background in working closely with teachers in reflecting on and improving their practice. The ISA coach works with the school over a four-year period at the school site, supporting school administrators and dedicated teacher/counselor teams as they implement the seven ISA principles to meet the needs of their school community.

The ISA coach works with individual teachers to strengthen their pedagogical skills and facilitates curriculum development and implementation. He or she helps the teacher/counselor teams to create a personalized, supportive environment that optimizes student learning. The team is further assisted with the implementation of ISA's Distributed Counseling™ model and their efforts to increase the level of parent involvement are informed by ISA best practices. ISA also helps schools to develop extended day programming that reinforces school day learning and offers young people opportunities to prepare for college and career.

THE CONCEPTUAL AGE

Our mission today is even more important than it was when ISA was founded because of the dramatic transformation of our economy and the nature of work. The fact is, we are charged with preparing our children to succeed in a world that in many ways bears little relation to the world we entered when we left school—or even the world we woke up in yesterday. In a microscopic measure of human time, we have moved through the Agricultural Age, to the Industrial Age, to the Information Age, and now to another era altogether. Author Daniel Pink calls this new era

the Conceptual Age. It requires us to be not only knowledgeable and competent, but creative and inquisitive as well.

Studies have shown that many of our high schools, even those that boast of high graduation and college-attendance rates, rarely demand that students use information, skills, and technologies to construct new knowledge and to solve complex problems, integrate concepts and ideas across disciplines, communicate effectively orally and in writing, and work in diverse groups. Yet this is precisely the kind of learning students need for a Conceptual Age. Students themselves tell us that they want to be held to high standards but that they find their high schools boring, unchallenging, and disconnected from their lives.

THE GLOBAL CHALLENGE

Microsoft Chairman Bill Gates recently told the Nation's governors that American high school education is "obsolete." He said, "When I compare our high schools to what I see when I'm traveling abroad, I am terrified for our workforce of tomorrow. . . . In 2001, India graduated almost a million more students from college than the United States did. China graduates twice as many students with bachelor's degrees as the United States and [has] six times as many graduates majoring in engineering. . . . America is falling behind."

Gates was describing a global economy in which the chance to move up into a better economic life is slipping overseas, along with jobs that can be performed anywhere—manufacturing in China, technology support in India, online order fulfillment across borders. The Internet brings Bhutan and Bangalore just as close to our offices and living rooms as Boise. Our children's competitors are not the other schools in the district or the State or even the Nation. They are the technologically literate young people in Taiwan, India, Korea, and other developing nations. For today's American students, learning and retraining will be a lifelong experience.

To be "competitive" now, U.S. students must develop sophisticated critical thinking and analytical skills to manage the conceptual nature of the work they will do. They will need to be able to recognize patterns, create narrative, and imagine solutions to problems we have yet to discover. They will have to see the big picture and ask the big questions. How many high schools do you know that are nurturing minds like that?

The 12th-grade data from the Third International Mathematics and Science Study showed that of the 20 countries participating, only two—Cyprus and South Africa—scored lower than the United States. American students enrolled in the most advanced courses in math and science performed at low levels compared to students in other countries.

LEAVING SOME STUDENTS BEHIND

Two serious gaps hold back most of our students and risk the prosperous future of the entire country. The gap we hear least about is the one between a rigorous, intellectually challenging curriculum and the rote instructional program that is commonplace in far too many classrooms. The gap we hear much more about is the one in student achievement that is exposed when data is disaggregated by race, ethnicity, and family income. Our challenge is to ensure that both gaps are closed and that all children—not just some of them—receive a high-quality education that will prepare them well for the world in which they will live and work.

There are tremendous gaps in achievement among racial and ethnic groups within our own country. We are systematically leaving behind large numbers of our poor and minority students. On the 2005 National Assessment of Educational Progress, 39 percent of white eighth-graders scored at or above proficient on the math exam, while only 9 percent of African-American and 13 percent of Hispanics achieved at that level.

A U.S. Department of Education study shows that the average 12th-grade African-American student is reading and doing math at around the level of the average eighth-grade white or Asian student. Hispanic students are about as far behind. On the 2004 SAT, black students, on the average, scored 104 points lower on the math test and 98 points lower on the verbal test than white students. Between 25 to 30 percent of America's teenagers fail to graduate from high school with a regular diploma. That figure climbs to more than 50 percent for black male and Hispanic students.

Clearly, this is not the path to global competitiveness. The quality and the inequality of education in this country should be at the top of the agenda for every meeting of the school board and superintendent. An uneven playing field is everybody's turf—and it needs tending.

THE INSTITUTE FOR STUDENT ACHIEVEMENT IS SUCCEEDING

At a time when the vast majority of jobs require a college degree or some type of postsecondary degree, most low-achieving students are relegated to classrooms where remediation and instruction in low-level skills are the norm. But poor performance and a shortage of vision are not inevitable characteristics of our educational system. ISA is addressing this challenge.

Typically ISA schools have attendance rates of over 90 percent average daily attendance. Over 95 percent of graduates from ISA schools and learning communities have gone on to college. The small size, 400 students grades 9–12, results in a high level of personalization, individual student attention, extensive, professional development, a challenging curriculum, and family and community involvement. Our research has shown that ISA small schools and learning communities have higher graduation rates, very low dropout rates, outstanding student attendance, increased teacher satisfaction and are more cost effective than large high schools.

In fiscal year 2007, ISA has requested Federal funding to help us continue our work in developing rigorous college preparatory high schools in the States of Georgia, Virginia, New Jersey and New York. Beyond that, our goal, with your help, is to expand the number of ISA schools to over 100 throughout the Nation, over the next three years. When we have met that challenge we will have demonstrated that there are model public high schools that are successfully educating all students in high need communities to be conceptual thinkers and ready for the challenges we are confronting in today's global economy. We hope that the subcommittee can be supportive of our efforts and our request for funding.

PREPARED STATEMENT OF THE NATIONAL WRITING PROJECT

I am Richard Sterling, Executive Director of the National Writing Project (NWP). NWP is authorized under Title II, Subchapter C, Subpart 2 of the Elementary and Secondary Education Act of 1965. It has been authorized as part of ESEA since 1991.

I appreciate the opportunity to present this testimony requesting continued support for the National Writing Project. As you know, the Department of Education's (ED) fiscal year 2007 budget request to Congress did not include funding for this program.

NWP is a national organization, a network of local writing project sites, working with teachers of all subject areas and at all grade levels to improve the teaching of writing in the Nation's schools. Today there are 195 university-based writing project sites in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. NWP sites promote core principles of effective instruction while they respond to the needs of local schools and communities. The fiscal year 2006 appropriation for the NWP is $21.5 million. Another $22 million in local support is leveraged by writing project sites across the country.

By statute, the purposes of the NWP are to (1) "support and promote the expansion of the NWP network so that teachers in every region of the United States have access to an NWP program," (2) "ensure the consistent high quality of sites through ongoing review, evaluation, and technical assistance," and (3) "support and promote the establishment of programs to disseminate effective practices and research findings about the teaching of writing."

The Department of Education's justification for elimination of the NWP states that the ED is "eliminating small categorical programs that have limited impact and for which there is little or no evidence of effectiveness." In addition, the ED States that, "These small categorical programs siphon off Federal resources that could be used by State and local agencies to improve the performance of all students." In relation to the NWP network these findings are not adequately supported by the facts. The NWP's response follows:

RESPONSE TO THE STATEMENT: THE NWP HAS "LIMITED IMPACT"

It is difficult to understand the basis for the finding that the NWP has "limited impact." The impact of a funded project is determined by the scale of services provided and the value of those services to districts, schools, teachers, and students. In terms of the scale of its services, the NWP is by far the largest provider of professional development in writing in the country.

Data gathered by an independent evaluator, Inverness Research Associates (IRA), show the scale of NWP as it affects students. Approximately 1.95 million students are taught every year by teachers who received professional development services from writing project sites. In addition, NWP programs also directly serve 45,000 stu-

dents through school-year and summer youth writing programs each year. (Data available from IRA, www.inverness-research.org.)

Data also demonstrate the scale of NWP's reach to teachers across the country. The NWP network provides 19 hours of professional development to 1 out of every 8 secondary language arts teachers and 1 out of every 35 elementary school teachers every year.

In 2004–2005 alone, more than 3,000 teachers attended intensive NWP summer institutes. These summer institute participants directly teach more than 60,000 students during the school year. (Their students are representative of the student population: 42 percent students of color, 13 percent English language learners, 46 percent in Title I programs.) These 2004–2005 teacher-participants join the more than 12,000 writing project teacher-leaders from past summer institutes who are serving their home communities. Together, these teachers conducted 7,288 professional development programs for more than 141,000 educators in 2004–2005.

The network of 195 local sites is a unique national asset now providing geographical access to teachers in two-thirds of the counties in the Nation. In 2004–2005, 1,657 districts (1 out of ten in the Nation) and 2,907 schools (1 out of every 30 schools) chose to invest their professional development dollars with NWP local sites. Local writing project sites have formed ongoing partnerships with 371 districts and schools.

Thus, not only is the scale of work of the NWP network of national significance, there is strong evidence that the services offered are highly valued by States, local districts, schools, and teachers.

Expanding the NWP

Since 2000, the NWP network has added 60 new writing project sites in 30 states. Each year between 6 and 10 new sites are established in areas of the country that previously had not been served. This addresses the statutory requirement to expand the NWP network "so that teachers in every region of the United States have access to an NWP program." In addition to adding new sites, NWP has developed local satellite programs so that existing sites can provide services to teachers and schools at a distance from the host university. NWP receives an average of 12 requests for new sites and satellites each year from universities eager to bring the writing project to their local communities.

Assuring program quality

In order to ensure the quality of local sites, NWP has conducted an annual site performance review since 1994. As part of the process, each local writing project site completes an extensive performance survey of its programs as well as of its teacher and administrator participants. The statistical data from these surveys are independently analyzed and reported by IRA on an annual basis. Every site must reapply for funding each year, and the analysis of these data, along with the site application, are used in the site performance review. During this annual review process, some sites are identified as in need of technical assistance from the NWP. If the sites are unable to resolve their issues after this technical support, they are no longer eligible for Federal funding. Over the last 10 years, 51 site grants were not renewed; however, 8 of these sites were re-funded after a transition period that resolved their issues.

While each local NWP site receives a small amount of core funding from the Federal grant, the vast majority of the work done by each local NWP site is supported by States, counties, local school districts, and individual teachers. States, districts, and schools must make careful decisions about how they spend their resources for professional development—the fact that they continue to invest in the work of the NWP over many years is strong evidence of both the value and the effectiveness of NWP services.

RESPONSE TO THE STATEMENT: THERE IS "LITTLE OR NO EVIDENCE OF EFFECTIVENESS" OF THE NWP

The Program Assessment Rating Tool (PART) review concluded that "there is insufficient evidence on the overall effectiveness of NWP interventions." This assertion is based on incomplete information about a range of studies conducted on the effectiveness of NWP programs. In particular, the NWP PART section 2.1 provides incomplete information concerning long-term performance measures that NWP has employed to "focus on outcomes and meaningfully reflect the purpose of the program."

In fact, since its inception in 1974 as a single writing project site located at the University of California, Berkeley, NWP has supported its sites in conducting numerous studies on the effectiveness of their professional development programs and

contracted with third parties that have also conducted such studies. (Only two of these studies are referred to in the ED report.) Multiple research studies have shown that NWP programs significantly increase the instructional knowledge of teachers to teach writing. High quality quasi-experimental studies confirm significant gains for students of teachers who have participated in writing project programs. The NWP's website (www.writingproject.org) contains information on these and other recent studies.

The PART assessment is based on incomplete information about the establishment of long-term measures to ensure that NWP sites disseminate effective practices in NWP teacher training programs. Beginning in 1999, following the establishment of GPRA performance indicators by ED, NWP contracted with IRA to collect and analyze additional data on teacher satisfaction with the summer training they received and to assess their implementation of effective instructional strategies in the teaching of writing in the year following the training. Targets were established by ED for this indicator in 1999.

NWP has exceeded the target established for every year of the evaluation to date, with an average of 96 percent of elementary and secondary teachers reporting that they gained effective teaching strategies and up-to-date research that they can apply to their teaching. The independent evaluation also showed that instructional strategies that NWP participants learn in the institutes and use in their classrooms correlate positively with greater student achievement in writing on the NAEP Writing Assessment. This study is performed annually in partial fulfillment of requirements placed on the NWP by ED. To date, more than 15,000 teachers have been surveyed, with consistent results across all six years of the evaluation. (These annual reports are available at www.inverness-research.org, including The National Writing Project Client Satisfaction and Program Impact: Results from a Satisfaction Survey and Follow-up Survey of Participants at 2004 Invitational Institutes, December 2005.)

The NWP PART assessment was also conducted before the conclusion of five rigorous quasi-experimental design studies that measured the extent to which students of teachers who received training by an NWP site improved their writing skills. Student learning in writing project teachers' classrooms was studied relative to student learning in comparable non-writing project teachers' classrooms. A team of external evaluators reviewed all of the research proposals and also designed and oversaw the independent national scoring of student writing. These five quasi-experimental studies have been completed and the results have been submitted to ED as well as posted on the NWP website.

Central to each of the five studies conducted in 2004–2005 was the writing project site's commitment to understand what difference writing project professional development makes for participating teachers' practices and, in turn, what difference those changes in instructional practices make for student learning. Each study employed direct assessments of student writing, and each included carefully matched comparison classes and/or students. In an independent national scoring of student writing, NWP students' improvement outpaced that of students in carefully constructed comparison groups.

Every comparison across all five studies shows positive effects of NWP programming. Student results were strong and favorable in those aspects of writing that the NWP is best known for, such as organization and the development of ideas. Students in writing project classrooms made greater gains than their peers in the area of conventions as well, suggesting that even these basic skills benefit from the NWP approach to teaching writing. These quasi-experimental studies uniformly indicate positive effects for the students of teachers who participated in writing project programs.

These studies conform to the advice regarding rigor in quasi-experimental designs as offered by the Institute of Educational Sciences (IES) of ED.

RESPONSE TO THE STATEMENT: "SMALL CATEGORICAL PROGRAMS SIPHON OFF FEDERAL RESOURCES THAT COULD BE USED BY STATE AND LOCAL AGENCIES TO IMPROVE THE PERFORMANCE OF ALL STUDENTS"

Rather than "siphon off" resources, the Federal investment in the NWP helps to augment and amplify local expenditures in the improvement of writing. All NWP sites match their Federal base grant with State, local, and private funding at a ratio of at least 1:1. The Federal investment provides core funding for the NWP and enables local sites to leverage additional funds from a variety of sources, including host universities, surrounding school districts, private corporations, and other entities. The quantity and quality of local professional development depends on the modest Federal investment that has so clearly demonstrated its power to attract and focus local resources. Without these crucial Federal funds, the core writing

project work that develops teacher expertise and leadership and supports the dissemination of research and effective practices will simply cease to exist.

An independent analysis by IRA of cost-efficiency over the past five years highlights the cost effectiveness of the Federal investment in the NWP. Local sites have leveraged an average of $3.65 for every Federal dollar they received from the NWP.

The need for strong literacy skills for our Nation's students is a central tenet of all current school reform efforts. The NWP is a very good example of a Federal-local partnership that addresses this core need. The Federal funds: (1) enable local sites to maintain a minimal but critically important effective group of teacher-leaders, (2) develop ongoing working relationships between universities and school districts, (3) respond to local needs, and (4) provide support to all local sites so that they can continue to improve and expand their programs. In summary, the NWP provides high quality, large scale, and cost-effective support to teachers and students to improve writing and learning in the Nation's schools.

PREPARED STATEMENT OF THE STATE EDUCATIONAL TECHNOLOGY DIRECTORS ASSOCIATION

NCLB TITLE II, PART D—ENHANCING EDUCATION THROUGH TECHNOLOGY (EETT)

Members of the State Educational Technology Directors Association (SETDA) include the State directors of technology from the SEAs in all 50 States, D.C., and American Samoa. I am pleased to submit this information and data which demonstrates how EETT is being utilized in over 80 percent of school districts across this country. EETT supports all areas of NCLB, including:

—Closing the Achievement Gap
—Recruiting and Retaining Highly Qualified Teachers
—Improving Data Systems to Meet AYP

EETT is also a key foundation to address the critical STEM and Competitiveness issues and initiatives. EETT has already begun to address these needs and will continue to do so through programs with data to support their effectiveness, including:

—Improving math and science achievement
—Ensuring highly qualified teachers in math and science
—Ensuring students and teachers have skills to ensure that they are prepared for the global workforce

This testimony includes the following:

1. Key Examples that illustrate the key role EETT plays in helping schools, districts, and States to meet NCLB goals, but also demonstrate the focus on math, science, and improving students' abilities to compete in a global workforce.

2. Overview of National Trends Report on Round 3 of EETT Funding data and results; the entire report on how EETT funds were used in all 50 States and D.C. can be accessed at http://www.setda.org/content.cfm?sectionID=185.

1. KEY EXAMPLES

Improvements in Math and Science Achievement

Iowa's Success With Algebra.—In Columbus Community School District, with 70 percent high poverty and 65 percent Hispanic populations, the 8th grade in the 2001–02 school year scored only 51 percent of the students as proficient on the ITBS Math Assessment. Cognitive Tutor Algebra I implementation began in 2002 with the instructor rating a very high level of implementation by the CEO of the program. Columbus Students improved proficiency by 11 percent from Grade 8 to Grade 9. They continued to improve and were 74 percent proficient as 11th graders.

Louisiana's Online Algebra I Course.—Algebra I is often a predictor for success in high school and beyond. Louisiana implemented an online Algebra I course to provide additional opportunities for student achievement. Preliminary evaluations indicate that students in the online course, with similar pre-test scores are showing more significant achievement gains compared to the control group as indicated below:

Group	Pre-test (fall) mean	Post-test (spring) mean
Algebra I Online Students	13.3	17.2
Control Students	13.4	15.6

Michigan's Freedom to Learn Project.—This one-to-one initiative, which includes each student having a computer and professional development for teachers, showed significant impact with 7th-grade reading scores jumping from 29 percent to 41 percent and 8th-grade math scores increasing from 31 percent to 63 percent.

Closing the Achievement Gap

Missouri's eMINTS,—The eMINTS National Center provides tools to teachers in grades 3–5 to integrate multimedia into lessons. Three years of data analysis have demonstrated the highly positive effect of the program on student achievement. Performance in the fourth grade in the fiscal year 2002 cohort was essentially equalized between African-American and white students. Indeed, African-American students in eMINTS classrooms had a slightly higher average score in social studies for fiscal year 2002 than white students not enrolled in those classrooms; and in mathematics, the average performance between these two groups was almost identical.

West Virginia's Basic Skills Computer Education Program.—Researcher Dale Mann (ASBO, 2003) cited a direct correlation between pupil performance and technology in instruction through West Virginia's Basic Skills/Computer Education program. The study found that while per capita income had not changed between 1991 and 1998, the infusion of technology was the single factor that accounted for the State moving from 33rd among the States for student achievement to 11th. In a similar study, Mann found that the cost of advancing students one unit in reading by decreasing the class size cost $636 and using technology to achieve the same result cost $86 (Mann, 2003). Technology provides a key opportunity to increase student achievement.

Providing Opportunities to Rural and Small School Districts Through Distance Education.—The U.S. Department of Education and NCES' recent Distance Education Courses for Public Elementary and Secondary School Students: 2002–2003 (2005) documents the fact that smaller and rural schools use distance education opportunities more often, with a strong emphasis on foreign language courses. Additionally, 50 percent of districts that provide distance learning opportunities had students enrolled in Advanced Placement (AP) Courses. The recent NGA Summit on High School reform indicated the importance of students' access and participation in AP Courses. At least 80 percent of districts noted that distance education allowed them to increase the course offerings for their students. EETT provides a significant funding for these opportunities.

Recruiting and Retaining Highly Qualified Teachers

North Carolina's IMPACT Model Schools Grant.—This EETT grant program provides personnel, connectivity, hardware, software, and professional development to improve student achievement. A collaborative model, it focuses on using technology as a tool to encourage authentic, project-based learning incorporating 21st Century Learning Skills into all curriculum areas. In a time where more than one-half of all teachers leave the teaching field within the first three years, teachers who are scheduled to retire often choose to stay in these IMPACT schools, others request transfers into them, and new teachers clamor to be hired. "These teachers like the way technology is changing the way they teach, and the enthusiasm with which their students approach learning," says Frances Bryant Bradburn, Director of Instructional Technology for the North Carolina Department of Public Instruction. Additionally, the initial results from this quasi-experimental design evaluation demonstrate that:

—In first year, students in IMPACT schools had stronger growth than comparison school students, and for particular subgroups there was substantially stronger growth varying from small differences to about half a grade level of extra growth, depending on the outcome and grade level.

—IMPACT students often started lower than their comparison school counterparts, but caught up within one school year.

—In general, the most challenged IMPACT students showed the most growth in achievement.

Maryland Increasing Teacher Retention.—Nationally, 50 percent of teachers leave the field within the first three years of their careers. To provide additional support for new teachers, Prince George's County has utilized Intel's Teach to the Future to provide extensive technology integration training for teachers and opportunity for graduate credit. Associated with Towson University, the first cohort of 125 beginning teachers are demonstrating a very high rate of retention: 94 percent.

Improving Data Systems to Meet AYP

Vermont Education Data Warehouse.—EETT funds in Vermont are being utilized directly for the implementation of data systems to support NCLB Accountability requirements through the Vermont Data Consortium that is creating a statewide

"Education Data Warehouse." The State grants provided through EETT funds support LEAs or schools in the development of local data systems to improve student achievement, support for teachers in analyzing data, improvement in evidence-based policy, and data standards to address local interoperability.

Philadelphia's Instructional Management System (IMS).—A comprehensive reform effort that includes new resources, a standardized curriculum, after school programs, and professional development, IMS provides teachers and administrators with immediate data on student learning aligned to State and District standards. A benchmark assessment, given every five weeks, allows teachers to differentiate instruction, provide immediate remediation, and identify those students who need additional assistance. In 2003, before these technology tools were provided to teachers, only 9 of the 40 initial participating schools had met AYP; and 15 were identified for Corrective Action. At the end of the 2004 school year, 25 schools met their AYP targets, and only 10 remained in Corrective Action II.

2. OVERVIEW OF NATIONAL TRENDS REPORT ON EETT

Key Findings

1. Promising Interim Results at 3-Year Mark Warrant Continued Investment
2. States Have Set the Bar High for Professional Development
3. States Are Making Progress with Evaluation and Impact Research
4. States Are Leveraging Resources through Collaborations and Partnerships

Over 40 percent of States required LEAs that received NCLB II D competitive grant funds to focus on reading or mathematics. States are not only building the conditions essential to effective technology use, but they are also seeing results as measured in increased student learning.

Nearly 25 percent of States are funding or commissioning research studies on the impact of educational technology on learning in schools. Over 88 percent of States are collecting data annually from either districts, schools, or both. States are increasingly triangulating data sources (e.g., district surveys, school surveys, teacher surveys, student surveys, and site visitations).

43 percent of the States went beyond the Title II D's 25 percent minimum funding requirement to focus additional resources toward professional development. Thus, over $159 million of grant funds was dedicated to professional development during Round 3 of the NCLB II D program.

Key Facts

1. Within the 50 States and the District of Columbia, 14,291 districts were eligible for Title II D funds, representing 89.3 percent of LEAs. Collectively, the survey respondents administered $635,027,468 in NCLB Title II D funding for Round 3, fiscal year 2004.

2. Most States are encouraging school districts and schools to integrate technology systematically and 23.5 percent actually require that technology planning and school improvement be conducted within the same process.

3. Funds are administered through both formula grants and competitive grants. Approximately 48 percent of the formula grants are under $5,000. That means that less than 4 percent of the funds require almost 50 percent of the administrative support for formula grants.

4. The following States report that NCLB II D is the only source of funding in their State for educational technology: Arizona, California, Delaware, Illinois, Louisiana, Maryland, Michigan, Minnesota, Missouri, New Hampshire, Oklahoma, Vermont, Washington, and Wisconsin.

5. On the other hand, many States, including Virginia, Pennsylvania, Florida and Alabama, are leveraging EETT to secure significant State investments in education technology through on-line assessment, high school reform, one to one initiatives and on-line learning initiatives.

Full copies of the National Trends Report are available for download from the State Educational Technology Directors Association (SETDA) Website, www.setda.org. SETDA is the principal association representing the State directors for educational technology. SETDA?s membership includes all 50 States, the District of Columbia, and American Samoa.

Thank you for your consideration of this data. Please contact me at mwolf@setda.org or 410-647-6965 with any questions.

RELATED AGENCIES

PREPARED STATEMENT OF THE NATIONAL FEDERATION OF COMMUNITY BROADCASTERS

Thank you for the opportunity to submit testimony to this subcommittee regarding the appropriation for the Corporation for Public Broadcasting (CPB). As the President and CEO of the National Federation of Community Broadcasters, I speak on behalf of 250 community radio stations and related organizations across the country. Nearly half our members are rural stations and half are minority controlled stations. In addition, our members include many of the new Low Power FM stations that are putting new local voices on the airwaves. NFCB is the sole national organization representing this group of stations which provide service in the smallest communities of this country as well as the largest metropolitan areas.

In summary, the points we wish to make to this subcommittee are that NFCB:

—Requests $430 million in funding for CPB for fiscal year 2009, a $30 million increase over the fiscal year 2008 advance appropriation;

—Requests $40 million in fiscal year 2007 for conversion of public radio and television to digital broadcasting. Also supports funding for the Public TV interconnection system;

—Requests that advance funding for CPB is maintained to preserve journalistic integrity and facilitate planning and local fundraising by public broadcasters;

—Reject the Administration's proposal to rescind $103 million of already-appropriated fiscal year 2007 and 2008 CPB funds;

—Supports CPB activities in facilitating programming and services to Native American, African American and Latino radio stations;

—Supports CPB's efforts to help public radio stations utilize new distribution technologies and requests that the subcommittee ensure that these technologies are available to all public radio services and not just the ones with the greatest resources.

Community Radio fully supports $430 million in Federal funding for the Corporation for Public Broadcasting in fiscal year 2009. Federal support distributed through CPB is an essential resource for rural stations and for those stations serving minority communities. These stations provide critical, life-saving information to their listeners and are often in communities with very small populations and limited economic bases, thus the community is unable to financially support the station without Federal funds.

In larger towns and cities, sustaining grants from CPB enable Community Radio stations to provide a reliable source of noncommercial programming about the communities themselves. Local programming is an increasingly rare commodity in a Nation that is dominated by national program services and concentrated ownership of the media.

For the past 30 years, CPB appropriations have been enacted two years in advance. This insulation has allowed pubic broadcasting to grow into a respected, independent, national resource that leverages its Federal support with significant local funds. Knowing what funding will be available in advance has allowed local stations to plan for programming and community service and to explore additional non-governmental support to augment the Federal funds. Most importantly, the insulation that advance funding provides "go[es] a long way toward eliminating both the risk of and the appearance of undue interference with and control of public broadcasting." (House Report 94–245.)

For the last few years, CPB has increased support to rural stations and committed resources to help public radio take advantage of new technologies such as the Internet, satellite radio and digital broadcasting. We commend these activities which we feel provide better service to the American people but want to be sure that the smaller stations with more limited resources are not left out of this technological transition. A step in this direction is the $3 million Internet Service Grant Fund that will help rural and minority stations serve their listeners and communities better through a website. We ask that the subcommittee include language in the appropriation that will ensure that funds are available to help the entire public radio system utilize the new technologies, particularly rural and minority stations.

NFCB commends CPB for the leadership it has shown in supporting and fostering the programming services to Latino stations and to Native American stations. For example, Satélite Radio Bilingüe provides 24 hours of programming to stations across the United States and Puerto Rico addressing issues in Spanish of particular interest to the Latino population. At the same time, American Indian Radio on Satellite (AIROS) is distributing programming for the Native American stations, arguably the fastest growing group of stations. There are now over 33 stations controlled by and serving Native Americans.

Last year CPB funded the establishment of the Center for Native American Public Radio (CNAPR). Based on a comprehensive assessment of the Native American Radio System, CNAPR will develop new funding sources for Native stations and programming; provide direct services to the Native Radio System; encourage collaborations; and represent the Native Radio System. These stations are critical in serving local isolated communities (all but one are on Indian Reservations) and in preserving cultures that are in danger of being lost. CPB's assessment recognized that ". . . Native Radio faces enormous challenges and operates in very difficult environments." CPB funding is critical to these rural, minority stations. CPB's funding of the Intertribal Native Radio Summit in 2001 helped to pull these isolated stations together into a system of stations that can support each other. The CPB assessment goes on to say: "Nevertheless, the Native Radio system is relatively new, fragile and still needs help building its capacity at this time in its development." The Center for Native American Public Radio promises to leverage additional, new funding to ensure that these stations can continue to provide essential services to their communities.

CPB also funded a Summit for Latino Public Radio which took place in September 2002 in Rohnert Park, California, home of the first Latino Public Radio station. These Summits have expanded the circle of support for Native and Latino Public Radio and identified projects that will improve efficiency among the stations through collaborations and explore new ways of reaching the target audiences.

CPB plays a very important role for the public and Community Radio system. They are the convener of discussions on critical issues facing us as a system. They support research so that we have a better understanding of how we are serving listeners. And they provide funding to programming, new ventures, expansion to new listeners, and projects that improve the efficiency of the system. This is particularly important at a time when there are so many changes in the radio and media environment with new distribution technologies and media consolidation. An example of this support is the grant that NFCB received to update and publish our Public Radio Legal Handbook online. This provides easy-to-read information to stations about complying with governmental regulations so that stations can function legally and use their precious resources for programming instead of legal fees.

Finally, Community Radio supports $40 million in fiscal year 2007 for conversion to digital broadcasting by public radio and television. It is critical that this digital funding be in addition to the on-going operational support that CPB provides. The President's proposal that digital money should be taken from the fiscal year 2007 CPB appropriation would effectively cut stations' grants by over 20 percent. This would have a devastating impact as stations trying to recover from hard economic times. And it would come at a time when the local voices of community and public radio are especially important to notify and support people during emergency situations and to help communities deal with the loss of loved ones—things that commercial radio is no longer able to do because of media consolidation.

While public television's digital conversion needs are mandated by the FCC, public radio is converting to digital to provide more public service and to keep up with what commercial radio is doing. The Federal Communications Commission has approved a standard for digital radio transmission. CPB has provided funding for 461 transmitters to convert to digital, is supporting additional research on AM radio conversion, and is working with radio transmitter and receiver manufacturers to build in the capacity to provide a second channel of programming. Most exciting to public and community radio is the encouraging results of tests that National Public Radio has conducted, with funding from CPB, that indicate that stations can broadcast at least two high-quality signals, even while they continue to provide the analog signal. The development of second audio channels will potentially double the public service that public radio can provide, particularly in service to unserved and underserved communities. This initial funding still leaves nearly 400 radio transmitters that will ultimately need to convert to digital or be left behind.

Federal funds distributed by the CPB should be available to all public radio stations eligible for Federal equipment support through the Public Telecommunications Facilities Program (PTFP) of the National Telecommunications and Information Agency of the Department of Commerce. In previous years, Federal support for public radio has been distributed through the PTFP grant program. The PTFP criteria for funding are exacting, but allow for wider participation among public stations. Stations eligible for PTFP funding and not for CPB funding include small-budget, rural and minority controlled stations and the new Low Power FM service.

We appreciate Congress' direction to CPB that it utilize its digital conversion fund for both radio and television and ask that you ensure that the funds are used for both media. Congress stated, with regard to fiscal year 2000 digital conversion funds:

"The required (digital) conversion will impose enormous costs on both individual stations and the public broadcasting system as a whole. Because television and radio infrastructures are closely linked, the conversion of television to digital will create immediate costs not only for television, *but also for public radio stations* (emphasis added). Therefore, the Committee has included $15,000,000 to assist radio stations and television stations in the conversion to digitalization . . ." (S. Rpt. 105–300)"

Community Radio also supports funding for the public television interconnection system. Interconnection is vital to the delivery of the high quality programming that public broadcasting provides to the American people.

This is a period of tremendous change. Digital is transforming the way we do things; new distribution avenues like digital satellite broadcasting and the Internet are changing how we define the business we are in; the concentration of ownership in commercial radio makes public radio in general, and Community Radio in particular, more important as a local voice than we have ever been. New Low Power FM stations are providing new local voices in their communities. Community radio is providing essential local emergency information, programming about the local impact of the major global events taking place, culturally appropriate information and entertainment in the language of the native culture, as well as helping to preserve cultures that are dying out. During the natural disasters of this last year, radio proved once again to be the most dependable, available medium to get emergency information to the public.

During these challenging times, the role of CPB as a convener of the system becomes even more important. The funding that it provides will allow the smaller stations to participate along with the larger stations which have more resources, as we move into a new era of communications.

Thank you for your consideration of our testimony.

PREPARED STATEMENT OF THE NATIONAL MINORITY CONSORTIA

The National Minority Consortia (NMC) submits this statement on the fiscal year 2009 appropriation for the Corporation for Public Broadcasting (CPB). The NMC is a coalition of five national organizations dedicated to bringing a significant amount of programming from our communities into the mainstream of public broadcasting and to other media. The role we fulfill in this regard is crucial to public broadcasting's mission. We are unique as organizations and as a coalition of organizations in the services we provide to our communities and to public broadcasting. In summary, we ask the Committee to:

—Direct CPB to increase its efforts for diverse programming with commensurate increases for minority programming and the National Minority Consortia
—Direct CPB to continue its support for the Native radio system
—Recommend at least $430 million for CPB core funding for fiscal year 2009, a $30 million increase over fiscal year 2008 and the amount being requested by CPB
—Reject the Administration's proposal to end advance funding for CPB
—Reject the Administration's proposal to rescind $103 million of already-appropriated fiscal years 2007 and 2008 CPB funds

REPORT LANGUAGE

We ask for Committee report language, as a follow-up to report language from last year, which recognizes the contribution of the NMC and directs that the CPB partnership with us be expanded. The report from last year stated:

"The Committee recognizes the importance of the partnership CPB has with the National Minority Public Broadcasting Consortia, which helps develop, acquire, and distribute public television programming to serve the needs of African American, Asian American, Latino, Native American, Pacific Islander, and many other viewers. As many communities in the Nation welcome increased numbers of citizens of diverse ethnic backgrounds, the local public television stations should strive to meet these viewers' needs. With an increased focus on programming to meet local community needs, the Committee encourages CPB to support and expand this critical partnership." (S. Rpt. 109–103, p. 298)

We request that the above language be modified to direct CPB to increase its support of the NMC and that it also include a reference to radio.

FISCAL YEAR 2009 APPROPRIATION

We support a fiscal year 2009 Federal appropriation for CPB of at least $430 million. This would be a reasonable, albeit modest, contribution toward our national treasure of public broadcasting. The quality gap between network television and public television has never been wider, and it continues to grow with each new "reality" show.

Public broadcasting, including PBS, NPR, and Native Radio is particularly important for our Nation's growing minority and ethnic communities. While there is a niche in the commercial broadcast and cable world for quality programming about our communities and our concerns, it is in the public broadcasting industry where minority communities and producers are more able to bring quality programming for national audiences. Additionally, public television and radio is universally available.

ADVANCE FUNDING

We strongly oppose the Administration's proposal that the advance funding for CPB be eliminated, a proposal that would stop CPB funding for two years. We appreciate that Congress has rejected this proposal each of the last five years. Reasons to continue advance funding for CPB include:

—The development of production of programming for public broadcasting usually takes several years and substantial lead time is necessary for planning productions.

—Public broadcasting programs are supported by multiple funding sources, and two years advance knowledge of the amount of Federal funding allows CPB to more effectively leverage its Federal funds to bring in other sources of revenue.

—The NMC administers a significant amount of CPB programming monies, and elimination of advance funding would negatively affect our organizations' planning, fundraising and producing work for public television and radio.

RESCISSION OF FISCAL YEAR 2007 AND 2008 FUNDS

We are extremely concerned about the Administration's proposal to rescind $103 million of already appropriated fiscal year 2007 and 2008 CPB funds ($53.5 million of fiscal year 2007 and $50 million of fiscal year 2008 funds). Such a rescission/diversion of funds would wreck havoc on our organizations and the independent producers that we help support as well as many radio and television stations.

NATIVE RADIO

Native American Public Telecommunications—one of the five National Minority Consortia organizations—works with both the radio and television sides of public broadcasting. NAPT operates American Indian Radio on Satellite (AIROS) which distributes programming to Native-owned and other radio stations. Koahnic Broadcasting Corporation, headquartered in Alaska, also produces and distributes Native American programming.

Native-owned radio is the fastest growing area of community radio. There are currently 33 Native-owned stations, all but one of which is located in Indian country. We greatly appreciate CPB's central role in the establishment late last year of the Center for Native American Public Radio (CNAPR), an organization that will provide technical and other services to Native radio stations. CNAPR's mission also includes developing new sources of revenue for the Indian radio system and being an advocate for Native radio. CPB is providing $1.5 million over a three-year period for CNAPR.

We ask that this Committee urge CPB to continue its support for Native radio.

ABOUT THE NATIONAL MINORITY CONSORTIA

With primary funding from the Corporation for Public Broadcasting, the NMC serves as an important component of American public television. By training and mentoring the next generation of minority producers and program managers we are able to ensure the future strength of public television and radio television programming from our communities. Individually, each Consortia organization is engaged in cultivating ongoing relationships with the independent producer community by providing technical assistance, program funding, programming support and distribution. Often the funding we provide is the initial seed money for a project, thus allowing it to develop. We also provide numerous hours of programming to individual public television and radio stations, programming that is beyond the production reach of most local stations.

While the Consortia organizations work on projects specific to their communities, the five organizations also work collaboratively. One example is our joint effort on the public television four-part series, Matters of Race that aired in the Fall of 2003. That series explored the complexity of our rapidly changing multiracial, multicultural society in America. The project resulted in more than television programming. The project was designed so that modules could be pulled out for classroom use. It was also formatted for radio broadcast and for the internet, and included extended interviews. This project provided a great opportunity for extensive and diverse community outreach and collaboration throughout its development, distribution, and use.

We also worked with American Public Television on 6 one-hour programs (named Colorvision) featuring the work of Native American, Asian American, Pacific Islander, Latino and African American filmmakers and television producers. It is now in national distribution for all public television stations.

Below is information about our individual organizations.

Center for Asian American Media

The Center's mission is to present stories that convey the richness and diversity of the Asian American experience to the broadest possible audience. Over our 25-year history we have provided funding for more than 200 projects, many of which have gone on to win Academy, Emmy and Sundance awards, examples of which are Daughter from Danang, Of Civil Wrongs and Rights; The Fred Korematsu Story; and Maya Lin: A Strong Clear Vision. The Center reaches large audiences through the annual International Asian American Film Festival and distributes Asian Pacific American media to schools, colleges, and universities.

Latino Public Broadcasting

LPB supports the development, production, acquisition and distribution of noncommercial educational and cultural television, representative of Latino people. The resulting programs, disseminated to public television and other public telecommunications entities, provide a voice to the diverse Latino community throughout the United States. Productions that have received LPB support include Mirror Dance; Visiones: Latino Art and Culture; Life and Time of Frida Kahlo; The Blue Diner; Farmingville; and The New Americans.

National Black Programming Consortium

The mission of NBPC, founded in 1979, is to preserve and promote complex and dynamic stories of the African Diaspora through program development, outreach and audience development, and professional development. NPBC has provided hundreds of hours of programming to the national PBS schedule; provided seed money to hundreds of projects by African American and other producers, and served as a window for emerging producers to break into the national; public broadcasting system. Currently under production is a film on issues surrounding Hurricane Katrina. During Black History Month in 2005, over 30 hours of programming were fed to stations. Examples of NBPC-supported programs are Two Towns of Jasper; The Murder of Emmett Till; A Doula Story; and Daughters of the Dust.

Native American Public Telecommunications

NAPT, founded in 1977, utilizes various media—public television, public radio, and the internet—to bring awareness of Indian and Alaska Native issues to the Nation. We market and distribute up to 10 hours per year on public television stations nationwide and fund 5 to 10 new Native productions annually. NAPT operates American Indian Radio on Satellite (AIROS) which distributes programming to the 33 Native-owned radio stations and other radio stations. Among the programming we offer is a national daily radio talk show, Native America Calling, on Native subjects, and we also cover live major Indian events. Between 2002 and 2005, NAPT delivered or supported the delivery of 24 hours of programming to public television. We also funded 30 projects, represented by 54 producers. NAPT projects garnered 3 national awards and 15 film festival awards during this time period.

Pacific Islanders in Communications

PIC delivers programs and training that bring new voice and visibility to Pacific Islands. A recent program which we helped bring into being is the award-wining Whale Rider, a story about a young Maori girl who confronts years of tribal tradition to fulfill her destiny as the leader of her people. When this program was aired on PBS, 107 million households watched the film. In partnership with the Girl Scouts, we held free screenings of the film and developed a website about the Maori people. PIC offers a wide range of development opportunities for Pacific Island producers through travel grants, seminars and media training.

CPB Funds for the National Minority Consortia

The National Minority Consortia currently receives funds from two portions of the CPB budget, organization support funds from the Systems Support and programming funds from the Television Programming sections. CPB financial support is critical to the work of our organizations. We believe that we make a major contribution to public broadcasting with a very modest amount of funding, but there is so much more that should be done.

The organizational support funds we receive from CPB are used not only for operations requirements but for also for a broad array of programming support activities and for outreach to our communities. We received $1.8 million in fiscal year 2006 CPB funds for organizational support ($370,000 for each organization). This represents 0.45 percent of the fiscal year 2006 CPB appropriation. We have received only very small increases in operations support funds in the past several years.

The programming funds we receive from CPB are re-granted to producers, used for purchase of broadcast rights and other related programming activities. Each organization solicits applications from our communities for these programming funds. We received $3.1 million in fiscal year 2006 CPB funds for programming ($636,363 for each organization). This represents 0.78 percent of the fiscal year 2006 CPB appropriation. Our CPB programming funds have remained virtually flat over the past nine years, despite increases in CPB appropriations.

Thank you for your consideration of our recommendations. We see new opportunities to increase diversity in programming, production, audience, and employment in the new media environment, and we thank Congress for support of our work on behalf of our communities.

PREPARED STATEMENT OF THE RAILROAD RETIREMENT BOARD

Mr. Chairman and Members of the Committee: We are pleased to present the following information to support the Railroad Retirement Board's (RRB) fiscal year 2007 budget request.

The RRB administers comprehensive retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement and Railroad Unemployment Insurance Acts. The RRB also has administrative responsibilities under the Social Security Act for certain benefit payments and Medicare coverage for railroad workers. During fiscal year 2005, the RRB paid nearly $9.2 billion in retirement/survivor benefits to about 634,000 beneficiaries, and $72.9 million in unemployment/sickness insurance benefits to about 29,000 claimants.

We are requesting $103,517,570 for agency operations in fiscal year 2007, which is the same as the amount included in the President's proposed budget. We are also requesting a legislative change to permit the RRB to continue using the services of the Department of the Treasury for disbursement of retirement and survivor benefits. In addition, we are requesting that the appropriations language for the Dual Benefits Payments Account be revised to make it clear that a rescission does not preclude the availability of the 2 percent supplemental funding in that appropriation.

AGENCY ADMINISTRATION

The President's proposed budget would provide $2 million more than the RRB's appropriation for fiscal year 2006. The increase is intended to provide for information technology improvements, which are needed to maintain the agency's service delivery systems. We estimate that under current legislation, the President's proposed budget would provide sufficient funding for a staffing level of 895 FTE's, which is 53 FTE's less than we expect to use in fiscal year 2006. In order to reach this level, we would need to conduct a reduction-in-force (RIF) of about 31 employees at an estimated cost of $394,000. However, the RIF could be avoided if the RRB is not required to contract for the services of a nongovernmental disbursement agent in fiscal year 2007, as discussed in the following section.

Administrative funding requested for fiscal year 2007 includes a total of $2.7 million for information technology investments, of which $1,557,000 would be used for a project begun in fiscal year 2005, to transition our mainframe non-relational database management system to a current technology relational database management system, DB2. The project, which directly correlates with our Enterprise Architecture Strategic Plan, will reduce the RRB's dependency on declining technologies, with their attendant risk of failure, and enable the agency to move ahead with further improvements to the benefit payment systems. In fiscal year 2007, we plan to use contractual support to optimize the performance of our databases and further reduce

data redundancy in order to ensure acceptable response times and system availability.

We are also moving forward to streamline the RRB's field service operations. In fiscal year 2005, we approved a high-level plan to restructure the field service into a hub and satellite configuration that will enhance the agency's ability to distribute work more efficiently among offices. In fiscal year 2006, we hired a consultant to assist in developing a 5-year plan that will include consolidation, co-location, and/or the establishment of virtual offices in the field service. The plan is to identify out-year savings while maintaining good customer service.

NONGOVERNMENTAL DISBURSEMENT AGENT

Section 107(e) of the Railroad Retirement and Survivors' Improvement Act of 2001 (Public Law 107–90) provides for contracting with a nongovernmental agent for the disbursement of railroad retirement benefits. However, initial market research has indicated that the cost of doing so would be about three times the cost of having similar services provided by the Department of the Treasury. In addition, our Inspector General has questioned whether certain services provided by the Department of the Treasury, such as reclamations, would be provided as effectively by a nongovernmental disbursement agent.

We have concluded that outsourcing this function would be inconsistent with the President's policy of outsourcing only where the government would reduce costs. For fiscal years 2005 and 2006, the Congress added language to our appropriations bill prohibiting this transfer: Section 516 of Public Law 109–149, the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2006 provides that none of the funds appropriated under the Act are to be used to contract with a nongovernmental disbursement agent. The RRB also submitted separate legislation to the Congress on May 5, 2005, to address this issue.

Our estimates indicate that the cost of contracting with a nongovernmental disbursement agent would be about $3 million for the first year and $2.3 million in subsequent years. By comparison, the annual cost of having these services provided by the Department of the Treasury is about $800,000. Enactment of legislation to remove this requirement would provide sufficient savings in fiscal year 2007 to enable the RRB to cover essential operating costs at the proposed budget level.

VESTED DUAL BENEFITS PAYMENTS APPROPRIATION

The President's proposed budget includes $88 million to fund the continuing phase-out of vested dual benefits, plus a 2 percent contingency reserve, $1,760,000, which "shall be available proportional to the amount by which the product of recipients and the average benefit received exceeds $88,000,000."

The requested funding level of $88 million reflects the RRB Chief Actuary's current estimate of the amount needed to pay full benefits in fiscal year 2007. However, the estimate does not provide for the effect of a possible rescission, which could significantly reduce the total amount provided in the budget year. Because the Dual Benefits Payments Account is classified as discretionary rather than mandatory, appropriations to the account have been reduced in recent years by across-the-board rescissions enacted as part of the annual appropriations process. The reductions have created a risk that vested dual benefits payments would need to be reduced due to insufficient funding in the account.

The Railroad Retirement Act provides that vested dual benefits payments in a fiscal year may not exceed the amount appropriated for that year. If the amount appropriated is not sufficient to fund full payments, individual vested dual benefits must be reduced on a pro rata basis. However, the current appropriations language is unclear as to whether the 2 percent contingency reserve would be available to cover a shortfall due to a rescission. We request that the appropriations language be revised to clarify that the contingency reserve may be used if needed to prevent a reduction of current-year benefits for any reason.

In addition to the requests noted above, the President's proposed budget includes $150,000 for interest related to uncashed railroad retirement checks.

FINANCIAL STATUS OF THE TRUST FUNDS

Railroad Retirement Accounts.—The RRB continues to coordinate its activities with the National Railroad Retirement Investment Trust (NRRIT), which was established by the Railroad Retirement and Survivors' Improvement Act of 2001 to manage and invest railroad retirement assets. Through fiscal year 2005, the RRB transferred a total of $21.276 billion to the NRRIT for this purpose. During the same period, the NRRIT transferred $2.673 billion to the Railroad Retirement Account for payment of retirement and survivor benefits. As of September 30, 2005, the market

value of NRRIT-managed railroad retirement assets was approximately $27.7 billion.

In June 2005, we released the annual report on the railroad retirement system required by Section 22 of the Railroad Retirement Act of 1974, and Section 502 of the Railroad Retirement Solvency Act of 1983. The report, which reflects changes in benefit and financing provisions under the Railroad Retirement and Survivors' Improvement Act of 2001, addresses the 25-year period 2005–2029 and contains generally favorable information concerning railroad retirement financing. The report includes projections of the status of the retirement trust funds under three employment assumptions. These indicate no cash flow problems throughout the projection period. The findings represent an improvement over last year's report and reflect continued favorable employment experience in the railroad industry.

Railroad Unemployment Insurance Account—The equity balance of the Railroad Unemployment Insurance Account at the end of fiscal year 2005 was $94.2 million, an increase of $14.3 million from the previous year. The RRB's latest annual report on the financial status of the railroad unemployment insurance system was issued in June 2005. The report indicated that even as maximum daily benefit rates rise 39 percent (from $56 to $78) from 2004 to 2015, experience-based contribution rates maintain solvency, with the exception of small, short-term cash flow problems in 2007 and 2008. Projections show quick repayment of the loans, even under our most pessimistic assumption. The average employer contribution rate remains well below the maximum throughout the projection period, but a 1.5 percent surcharge is now in effect and is expected for calendar year 2007. We did not recommend any financing changes based on this report.

In conclusion, we want to stress the RRB's continuing commitment to improving our operations and providing quality service to our beneficiaries. Thank you for your consideration of our budget request. We will be happy to provide further information in response to any questions you may have.

PREPARED STATEMENT OF THE RAILROAD RETIREMENT BOARD

Mr. Chairman and members of the subcommittee: My name is Martin J. Dickman, Inspector General of the Railroad Retirement Board (RRB). I would like to thank you, Mr. Chairman, and the members of the committee for your continued support for the Office of Inspector General. I wish to describe our fiscal year 2007 appropriations request and our planned activities.

The Office of Inspector General requests funding of $7,606,000 to ensure the continuation of its independent oversight of the RRB. The agency is responsible for managing benefit programs which paid $9.2 billion in retirement and survivor benefits to approximately 634,000 beneficiaries in fiscal year 2005 and an additional $73 million in net railroad unemployment and sickness insurance benefits to 29,000 claimants. The RRB also administers Medicare Part B, the physician services aspect of the Medicare program, for qualified railroad retirement beneficiaries. Through this program, approximately $870 million in annual Medicare benefits are paid to approximately 535,000 beneficiaries.

In fiscal year 2007, the Office of Inspector General will continue to concentrate its efforts on the performance of reviews of significant policy issues and program operational areas. We will coordinate our efforts with agency management to identify and eliminate operational weaknesses. We will also continue our investigation of allegations of fraud, waste and abuse, and refer cases for prosecution and monetary recovery action.

We also request the removal of the prohibition on the use of appropriated funds for any audit, investigation or review of the Railroad Medicare program. The RRB manages a nationwide contract for processing Medicare Part B claims for railroad beneficiaries. The agency is responsible for the enrollment of beneficiaries, premium collection, answering beneficiary inquiries and conducting the annual Carrier Performance Evaluation for the Medicare carrier.

The prohibition does not permit this office to fulfill its statutory oversight responsibilities for a major agency program. Removal of the prohibition would benefit both the Railroad Retirement Board and its constituents, and would be consistent with the priorities established by the Administration and the Congress to reduce fraud in one of the largest Federal programs.

We also request oversight authority to conduct audits and investigations of the National Railroad Retirement Investment Trust (NRRIT), the body responsible for the investment of approximately $29 billion in trust funds used to support Railroad Retirement Act benefit programs. This office would ensure sufficient reporting mechanisms are in place and that the NRRIT members are fulfilling their fiduciary

responsibilities. We have repeatedly expressed concerns about RRB management's passive relationship with the NRRIT, and identified the issue as a serious challenge for the RRB.

We are currently required to reimburse the agency for office space, equipment, communications, office supplies, maintenance and other administrative services. We are the only Federal OIG that cannot negotiate a service level agreement with its parent agency, and, therefore, request that the current appropriation language be amended accordingly.

OFFICE OF AUDIT

Auditors will perform the audit of the RRB's 2006 financial statements and preliminary work for the 2007 financial statements to ensure the issuance of reliable financial information. The OIG will obtain contractor actuarial services to audit the statement of social insurance.

Audit staff will work with agency management to ensure detailed and verifiable financial information is available from the National Railroad Retirement Investment Trust (NRRIT). As discussed above, we believe RRB management should take a more active interest in NRRIT activities.

Auditors will conduct the annual evaluation of the RRB's information systems security to meet the requirements of the Federal Information Security Management Act of 2002. They will also monitor the agency's information systems operations to determine if the agency is meeting the goals established in its Strategic Information Resources Management Plan and to ensure the agency is in compliance with the provisions of the Information Technology Management Reform Act.

Auditors will continue to monitor agency actions to address security deficiencies and complete corrective actions. They will ensure that network and system security safeguards are in place to protect the confidentiality of sensitive financial and personal information. Auditors will also perform assessments of the agency's e-government initiatives to identify and eliminate system vulnerabilities, and to ensure compliance with the E–Government Act of 2002. We will continue our monitoring efforts of the RRB's document imaging activities and the expansion of paperless processing to ensure the integrity of records.

Auditors will continue to review RRB benefit processes and procedures to identify ways to reduce administrative and adjudicative errors. They will offer recommendations to strengthen the agency's debt collection program to reduce the outstanding receivables.

OFFICE OF INVESTIGATIONS

The Office of Investigations (OI) identifies, investigates and presents cases for prosecution, throughout the United States, concerning fraud in RRB benefit programs. In fiscal year 2007, OI will continue to focus its resources on the investigation of cases with the highest fraud losses. OI currently has approximately 500 active investigations involving fraudulent benefit payments and fraudulent reporting with fraud losses of approximately $11.8 million. These cases involve all RRB programs that provide sickness and unemployment insurance benefits to injured or unemployed workers, retirement benefits, and disability benefits for workers who are disabled.

We will coordinate our efforts with agency program managers to address weaknesses in agency programs that allow fraudulent activity to occur, and will recommend changes to ensure program integrity.

We will concentrate resources on cases with the highest fraud losses, those related to the RRB's retirement and disability programs. OI will dedicate considerable time to the investigation of nationwide schemes to defraud the RRB disability program. Disability cases currently constitute about 44 percent of our investigative caseload. These cases involve more complicated schemes and result in the recovery of substantial funds for the agency's trust funds.

In fiscal year 2007, we will continue to use the Department of Justice Affirmative Civil Enforcement (ACE) program for those cases which do not meet the criminal guidelines of U.S. Attorneys. Through this program, we are able to obtain civil judgements and recover trust fund monies for the RRB.

SUMMARY

In fiscal year 2007, the Office of Inspector General will continue to focus resources on the reviewing RRB program operations and ensuring the integrity of agency trust funds. We will also continue to aggressively pursue individuals who engage in activities to fraudulently obtain RRB funds.

PREPARED STATEMENT OF THE NATURE CONSERVANCY

Mr. Chairman and members of the subcommittee, I appreciate this opportunity to present The Nature Conservancy's recommendations for fiscal year 2007 appropriations. The Nature Conservancy is an international, nonprofit organization dedicated to the conservation of biological diversity. Our mission is to preserve the plants, animals and natural communities that represent the diversity of life on Earth by protecting the lands and waters they need to survive. Our on-the-ground conservation work is carried out in all 50 States and in 27 foreign countries and is supported by approximately one million individual members. We have helped conserve nearly 15 million acres of land in the United States and Canada and more than 102 million acres with local partner organizations globally.

The Conservancy owns and manages approximately 1,400 preserves throughout the United States—the largest private system of nature sanctuaries in the world. We recognize, however, that our mission cannot be achieved by core protected areas alone. Therefore, our projects increasingly seek to accommodate compatible human uses, and especially in the developing world, to address sustained human well-being.

The focus of my testimony is on the Americorps National Civilian Conservation Corps (NCCC) program, which has made a tremendous contribution, as well as provided cost savings, to conservation and public recreation in the United States. The President's fiscal year 2007 Budget proposes to cut funding for the program from $26.7 million to $4.9 million, with the intention of eliminating the program completely. The Nature Conservancy urges the Committee to retain funding for the NCCC program at its current levels.

NCCC has been known in recent months for the critical support its participants provided to disaster relief efforts after Hurricane Katrina. We applaud those efforts. We also want to highlight the important conservation work that NCCC participants have engaged in over the past years. Many Federal, State, and local government agencies, as well as non-profit conservation organizations, use the NCCC program to implement Federal programs and to achieve significant public benefits at low cost. At the Conservancy, we have employed NCCC participants to do the following:

—Provide outdoor recreational opportunities and health benefits for Americans across the country;

—Use prescribed fire to reduce hazards to communities and restore ecosystems;

—Control invasive species; and

—Train the next generation of natural resource managers.

The program has saved our organization millions of dollars in recent years, and has provided work that would otherwise take years to accomplish, or simply would not get done at all. Below are some examples of specific results that NCCC has achieved.

PROVIDING AMERICANS WITH RECREATIONAL OPPORTUNITIES AND HEALTH BENEFITS

As the country's appetite for outdoor recreation grows—and issues like childhood obesity demonstrate the importance of increased outdoor activity—there is a growing need to provide safe, beautiful places for Americans to use and experience. The Nature Conservancy and our partners help provide these opportunities through a system of preserves and parks. Our efforts are significantly augmented by NCCC participants. The NCCC has built and maintained trails and boardwalks, restored campsites, repaired interpretive signs, provided wildlife protection, planted trees and developed archaeological dig sites. These activities provide the public with greater access to the outdoors, at low cost, and enhance the outdoors experience.

USING PRESCRIBED FIRE TO REDUCE HAZARDS AND RESTORE ECOSYSTEMS

As reflected in recent legislative actions, including passage of the Healthy Forests Restoration Act of 2004, reduction of hazardous fuels on the Nation's forested lands is one of the country's greatest land management challenges. President Bush has emphasized the need to reduce fire hazards to communities, and restore ecosystems, through prescribed burning and other management techniques. Each year, the U.S. Forest Service and the Department of the Interior set acreage goals for burning and related treatments. The Nature Conservancy provides training and personnel to assist in meeting these goals.

In recent years, NCCC participants have comprised a new cadre of fire managers, bringing skills and knowledge to individual projects, and assisting government agencies and non-profit land managers alike. The Nature Conservancy has used NCCC participants in at least eleven States to assist in burning tens of thousands of acres at a cost savings of several hundred thousand dollars. We also work with NCCC to

burn on military bases, U.S. Forest Service lands, State parks and natural areas, and other public lands.

On some projects, fire management results in restoration efforts that ease the burden on private landowners and Federal land managers in complying with the Endangered Species Act. For example, in Virginia, NCCC-assisted burns have restored habitat and supported the recovery of an endangered species, the red-cockaded woodpecker. Finally, NCCC participants assist land managers and public agencies in measuring performance and evaluating the success of fuels treatment efforts.

REDUCING THE THREAT OF INVASIVE SPECIES

Invasive species—primarily weeds and insects—are one of the principal threats to our natural resources across the United States; they have damaged many natural landscapes as well as reduced the value of working lands. NCCC participants have assisted in abating impacts of invasive species at many locations. Their activities have included controlling invasive plants that are destroying valuable salt marshes and fens in New York; restoring natural tallgrass prairie by removing invasive trees in Minnesota; and preserving riparian and old growth forest habitat in Oregon.

Along with actual removal of invasive species, NCCC participants have worked to educate the public on threats of invasive species and measures to control them.

BUILDING A NEW GENERATION OF NATURAL RESOURCE MANAGERS

As the country's population grows and threats to the environment increase, we face constant challenges to the conservation of our natural heritage. We will not be able to meet those challenges unless we encourage young people to pursue conservation careers and we provide them with the necessary training. The NCCC program has succeeded in doing this. Our experience is that NCCC participants are organized, well-trained and enthusiastic, and that they care deeply about conservation—in part because they understand the benefits to communities and to people that conservation provides.

In particular, because of the job training focus of NCCC, its participants make up a substantial portion of the country's future fire managers—a group of professionals we cannot afford to lose, given the hazards that wildfire poses to our communities. A significant portion of the Federal fire workforce will retire in the next five years, and the NCCC program plays a critical role in replenishing that workforce.

NCCC makes an important contribution to Americans' access to and enjoyment of the outdoors, as well as to conservation of our natural heritage. We urge the Committee to provide funding at current services levels for this important program.

Thank you again for the opportunity to testify. If you have questions, please contact Louise Milkman at 703–247–3675.

PREPARED STATEMENT OF THE VOICES FOR NATIONAL SERVICE

Mr. Chairman and members of the subcommittee: We are writing as members of Voices for National Service to urge you to reject funding cuts to AmeriCorps, Learn and Serve America, and the National Civilian Community Corps (NCCC) included in the Administration's fiscal year 2007 budget.

Voices for National Service is a coalition of more than 160 community-based organizations, faith-based groups, governor-appointed State commissions, private sector partners, institutions of higher education, and others dedicated to expanding opportunities for Americans to serve community and country.

Our message to the Labor-HHS Subcommittee is quite simple: AmeriCorps, Learn and Serve America, and the NCCC are cost-effective programs that meet critical community needs, and funding for these programs should be sustained and increased. While we recognize the fiscal constraints that lawmakers must operate under, now is not the time to cut funding for national service. We urge you to fund these programs at their fiscal year 2004 enacted levels:

—$441 million for AmeriCorps;
—$43 million for Learn and Serve America; and
—$26 million for the NCCC.

We would like to note the following areas of concern and consideration as they relate to the appropriation for these programs:

—We are concerned that the Administration's budget proposes to cut funding for the NCCC to $5 million in fiscal year 2007, and to eliminate the program by 2008. As numerous first-hand accounts by Gulf Coast residents, newspaper stories and op-eds have attested in the past weeks, the NCCC responded to the

crisis in the Gulf Coast heroically, deploying 1,600 members to the region who have provided critically needed services and support. This is not the time to eliminate a program with a proven track record in strengthening America's disaster preparedness and relief capacity.

—While we are eager for NCCC's funding to be reinstated, we hope that you will not preserve this program at the expense of other critical programs like AmeriCorps State and National and Learn and Serve America. Like the NCCC, these programs have had a profound impact in the Gulf Coast and in the communities they serve. Americans want to serve. We should be expanding their opportunities, not eliminating them.

—We are concerned that despite strong bipartisan support, the proposed budget would result in a 17 percent reduction in AmeriCorps State and National funding since fiscal year 2004. AmeriCorps is a critically needed program that provides opportunities for 70,000 Americans to serve each year, and its funding should be sustained or increased, not cut.

—We are concerned that the proposed funding cut to Learn and Serve America would have serious negative consequences for both the 1.5 million students who participate in this program and the communities they serve. Compared to its fiscal year 2004 funding level of $43 million, the proposed cut to $34.2 million would mean:

—300,000 fewer students serving their communities through Learn and Serve America;

—A loss of $34 million in leveraged private and community resources; and

—A decline of 7.3 million service hours to communities.

We are concerned that the Corporation for National and Community Service's plan to continue to recruit 75,000 AmeriCorps members in spite of the program's proposed cuts will be detrimental to programs running full-time, stipended corps. The proposed cuts include a $300 reduction in the average Federal contribution per full-time corps member. AmeriCorps programs have been required to absorb an increasing percentage of their program operating costs. As fixed and mandated costs grow, annual reductions in operating support are destabilizing the AmeriCorps field. Efforts to do more with less threaten AmeriCorps' historic mix of full-time and part-time, stipended and non-stipended corps.

ABOUT AMERICORPS, LEARN AND SERVE AMERICA, AND THE NCCC

AmeriCorps State and National is a network of local, State, and national service programs that connect at least 70,000 Americans each year in intensive service to meet our country's needs in education, public safety, health, and the environment.

Learn and Serve America provides State formula and competitive grants to support service-learning in K–12 schools, colleges and universities, and non-profit organizations. Service-learning integrates community service with academic study to enrich learning, teach civic responsibility, and strengthen communities. At an average cost of only $28 per participant, Learn and Serve America leverages private and community resources to yield $4 in services to the community for each $1 invested by the government. The program also fosters collaboration between educational institutions and civic, faith-based, and community groups to engage youth in meaningful service to address local needs, help young people answer President Bush's Call to Service, and assist in meeting the Corporation's strategic goal of having quality service-learning in half of all K–12 schools by 2010.

The AmeriCorps NCCC is a full-time residential program for men and women ages 18–24 that strengthens communities while developing leaders through direct, team-based national and community service. The NCCC is a trained force that can be immediately deployed. Four trained NCCC teams were pulled from other assignments and sent to support shelters in Mississippi and Alabama one day after Hurricane Katrina hit.

THE ROLE OF NATIONAL SERVICE IN MEETING CRITICAL NEEDS IN THE GULF COAST

The Administration's budget provides the NCCC with a modest $5 million appropriation to graduate its final class of corps members and permanently close the program's five regional campuses. The budget also proposes to cut funding for AmeriCorps State and National, reducing funding levels by 17 percent since fiscal year 2004. And yet as we write, thousands of AmeriCorps and NCCC members are on the front lines in the Nation's response to the greatest natural disaster in U.S. history, serving our Nation in the Gulf Coast.

To date, more than 13,000 national service members have contributed to hurricane relief efforts in the Gulf and around the country. NCCC members were among the first on the scene, and to date, 1,600 NCCC members have served on more than

100 separate disaster service projects in the Gulf Coast region, providing humanitarian aid and physical service, as well as managing the thousands of outside volunteers who want to help. This program embodies the important role that citizens must play in partnering with government to respond to community crises and national disasters.

According to Malcolm Jones, City Attorney of Pass Christian, Mississippi who worked closely with a team of NCCC members to provide services to town residents, "Our town, on the Gulf Coast of Mississippi, 7,000 people, we got the hardest part of [the storm]. When I came back after evacuating for Katrina. . . . I found out that AmeriCorps [is] a very powerful, powerful thing. [W]hen we lost hope, [AmeriCorps] came."

Because of AmeriCorps, young people from around the country are putting their talents to work in the Gulf Coast region by doing everything from clearing debris and repairing roofs in Mississippi, to preventing further damage to historic buildings in New Orleans, to managing a supply warehouse in Louisiana, and serving displaced residents aboard ships in Alabama. We would like to share a few of their stories with you as examples of the critical services that AmeriCorps and NCCC members are providing:

Kenye Quiroga was sent to Louisiana one week after joining AmeriCorps. He writes that, "While in D'Iberville we stayed on pallets in an old community center with only half a roof. The living definitely wasn't easy, but I had the opportunity to get to know some great people. By the end of our mission in D'Iberville, my team had assessed every household in the town and brought food, water, and medication to families who needed emergency supplies."

According to Kimberly Walker of Jackson, Mississippi, "In the aftermath of the Hurricane, Mississippi Primary Health Care Association served as one of the many distribution points to assist Hurricane victims with basic supplies. Our team . . . carried supplies to a larger designated distribution site and was able to meet and talk first hand to some of the victims. . . . We assisted in directing them to other services available to them."

Carrie Ann Smith from the West Seneca, New York AmeriCorps program was deployed to Slidell, Louisiana. She writes, "I felt like I was entering a war zone. I felt the pain and frustration that still loomed in the air, but most of all I felt the need to help, to serve, and to make a difference. That's what AmeriCorps does and I am proud to be a member of such a noble and upstanding organization. But even more so, I am proud to be an American who was given the opportunity to help my fellow Americans in a time of tragedy and such utter devastation. I would not have had that opportunity if not for AmeriCorps."

These young people, and thousands like them, served and continue to serve with great distinction, bringing hope and relief to fellow citizens, and learning the value of civic engagement and giving to communities in need. The national service response, however, has not been limited to the on-the-ground effort in the Gulf. In communities across the country, national service programs are joining with local, State and Federal agencies and nonprofit organizations to provide long-term relief to those uprooted and displaced by the storms. For example, tens of thousands of students supported by Learn and Serve America are collecting school supplies, raising funds and preparing disaster relief kits.

NATIONAL SERVICE ACCOMPLISHMENTS ACROSS AMERICA

In addition to responding to needs in the Gulf Coast region, AmeriCorps members are also serving in thousands of communities across the United States. Every day, 70,000 AmeriCorps members add value to school curricula by tutoring and mentoring, operating after-school programs, expanding the reach of community health centers, teaching in underserved public and parochial schools, and improving our environment.

Below are just a few examples of the many community needs that AmeriCorps members met in 2004–2005:

—In Florida, members recruited 2,000 community volunteers to provide education services, maintained and expanded 200 acres of habitat for threatened and endangered species, and built 40 homes for low-income families.

—In Kentucky, members educated more than 1,000 at-risk elderly about home safety and conducted 265 Home Safety Assessments for seniors.

—In Maryland, members removed 453 tons of trash, improving the quality of storm water run-off into the Chesapeake Bay and 1,900 homeless families received food, clothing, or furniture.

—In Mississippi, members conducted life skills trainings with 715 people with disabilities, helped train mentally and developmentally disabled adults for employ-

ment, and mentored 1,100 low income and underachieving middle school students.

—In New York, members transported 1,000 children to medical appointments, delivered meals and snacks to about 58,000 children and seniors, and provided literacy activities to almost 17,000 children.

—In Ohio, members trained more than 9,000 youth in conflict resolution, built repaired, or rehabilitated 364 housing units, and provided educational support services to 1,500 students during the summer months.

—In Pennsylvania, members tutored almost 14,600 elementary and high school students and more than 6,800 citizens received either needs assessment or support in the areas of domestic violence, foster care, mental health, and housing for homeless veterans.

IMPACT OF NATIONAL SERVICE PROGRAMS

In the last decade, more than 500,000 young Americans dedicated themselves to either full or part-time service through AmeriCorps to improve their communities and their country. Through dedicated service to our Nation, AmeriCorps members have earned Education Awards worth more than $1.5 billion that have helped them afford higher education or career training.

Evaluations prove that AmeriCorps works. Recent studies by the Center for Leadership and Public Service at Harvard University and Bridgestar indicate that the United States is facing a significant leadership gap in the next decade. Given the need for an emerging group of young leaders to fill leadership positions in the social, private, and public sectors, the results of AmeriCorps programs in terms of building civic skills and a commitment to public service are striking. To cite but a few examples of some of the positive results of recent program evaluations:

—A rigorous multi-site control group evaluation by Abt Associates and Brandeis University reported significant employment and earnings gains by young people who join service or conservation corps.

—A study of Teach for America (TFA) by Mathematica Research Group found that "it supplies low-income schools with academically talented teachers who contribute to the academic achievement of their students. TFA teachers . . . produce higher student test scores than the other teachers in their schools."

—An evaluation of City Year alumni by Policy Studies Associates showed that more than three-quarters of alumni reported an increased commitment to public responsibility and greater knowledge and skills that improved their ability to address and solve community problems.

Learn and Serve America has tremendous impact and support. According to a 2004 study by RMC Research, "Service-learning, when implemented with high quality, yields statistically significant impacts on students' academic achievement, civic engagement, acquisition of leadership skills, and personal/social development." Evaluations also indicate that the program correlates with a reduction in the number of behavioral problems, and reduced sexual activity and pregnancy among students.

THE FISCAL YEAR 2007 REQUEST

We understand the funding constraints of the current appropriations process, and appreciate your leadership in seeking to provide support to the many programs that are meeting community needs across the Nation in a challenging fiscal environment.

Given the track record of AmeriCorps, Learn and Serve America, and the NCCC in serving children, families, and communities and in responding effectively and efficiently to the recent disasters in the Gulf Coast region, we urge you to reject the funding cuts to these programs in the administration's fiscal year 2007 budget request and to fund these programs at their fiscal year 2004 levels. These programs have proven to be worthy of your investment.